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LIVING BETWEEN THE CRACKS: AMERICA'S CHRONIC HOMELESS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

PHILADELPHIA, PA

DECEMBER 12, 1984

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LIVING BETWEEN THE CRACKS: AMERICA'S CHRONIC HOMELESS

WEDNESDAY, DECEMBER 12, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Philadelphia, PA.

The committee met, pursuant to notice, at 9:20 a.m., at the Drop-In Center, Philadelphia, PA, Hon. John Heinz presiding.

Present: Senator Heinz.

Also present: Stephen R. McConnell, staff director; Paul Steitz, professional staff member; Isabelle Claxton, communications director; Claire Smreker, research associate; and Leslie Malone, staff assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Ladies and gentlemen, good morning.

This is a hearing of the U.S. Senate Special Committee on Aging, and we are here today because we want to hear testimony on the local effects of what has become a national crisis: The swelling ranks of homeless Americans. In a society plagued by holes in the "safety net" of support programs, the homeless stand apart. For these people, there has never been a net at all.

Next week, as many Americans finish decorating their Christmas trees, between 1 and 3 million Americans, close to 1 percent of the total population, will give as their address an abandoned car, a heating grate, or a street corner. In Philadelphia alone, 6,000 to 7,000 men, women, and children this year will have no place to call home.

Despite the stereotype each of us has formed, there is no "typical" street person. America's homeless today include, for example, the welfare mothers and children evicted from a tenement room; the unemployed workers who drift from town to town in search of jobs; the mentally disabled, turned out on the streets when the State institution closed, or were never admitted in the first place. And America's homeless are also the elderly couples scratching out a meager living on a fixed income who are forced to abandon their home when the taxes go up again.

Whatever their personal histories, America's homeless share the same brutal, isolated world, the same sense of disconnectedness from the rest of society.

While the plight of the Nation's homeless has attracted a great deal of concern and publicity in the past few years, and in particular in the past year, most public and private initiatives have fo-

cused on mobilizing resources to meet the immediate needs of food and shelter. Last year, the city of Philadelphia spent $7 million of its own funds in direct aid to the homeless. The Federal Government, in addition to all its other programs, provided $140 million nationwide in a special emergency program through the Federal Emergency Management Administration.

But even with these efforts, optimistic statistics show that only one in three homeless people will have a bed and a bowl of soup in a public or private shelter this winter. Other figures suggest that only a shocking 1 out of every 20 will be so lucky. Both figures illustrate how much is yet to be done. And they bring home the point that the crisis of the homeless can no longer be seen as a short-term phenomenon. We need to develop more comprehensive, more far-reaching policies to not only get people off the street for a night or two, but get them back to safe independent living in the community.

For two special groups of the homeless, the aged and the mentally ill, the need for a comprehensive long-term plan is particularly urgent. These individuals not only lack income, housing and health care, but their mental and physical limitations make independent living impossible without a safety belt of community-based services and rehabilitation options.

Between one-third and one-half of the homeless in America today suffer a severe mental handicap. As many as one in five are over age 60. These are America's chronic homeless. They live between the cracks in the Nation's relief system. Their lives go largely untouched by short-term emergency care or even national economic recovery. If we do not establish a better coordinated and integrated system of support for these groups, temporary shelters will become hopeless, long-term warehouses for the aged, and the streets will continue to serve as an open asylum for the mentally ill.

We need to tailor such existing Federal programs as Food Stamps, SSI, Social Security Disability and Medicaid to meet the special needs of the elderly and mentally handicapped homeless. We must galvanize American business and charitable groups to the cause and tap their resources to the fullest as well.

Meeting the real needs of the chronic homeless stands as a challenge of conscience to this country and all its public and private institutions. We must fashion an intelligent strategy to restore order and continuity to human beings whose lives, through no fault of their own, have been shattered. As a Nation, I believe we can do no less.

Our first group of witnesses is a panel, and I would like to ask Ronald Comer, who represents the Philadelphia Advocates for the Mentally Disabled, to introduce the panel and to proceed. Mr. Comer.

STATEMENTS OF RONALD C. COMER, M.A., PHILADELPHIA ADVOCATES FOR THE MENTALLY DISABLED, PHILADELPHIA, PA; FRANK FERRELL, TREVOR'S CAMPAIGN; TRACEY MELLOR, CASEWORKER, THE DROP-IN CENTER, AND HOMELESS PEOPLE, GERALDINE, FRED, RALPH, AND CHARLEY

Mr. COMER. Thank you very much, Senator Heinz.

We have some people here today who have come in to talk to the Senator about what it has been like for them to be homeless and what it is that they think that the Government can do and should be doing to help them in the plight they have experienced for months and years on the streets.

Geraldine has offered to come and speak. Could you speak for awhile, Geraldine?

GERALDINE. I would like to see if they can have jobs, more jobs available, and more money, checks, or all of us could have a check, some kind of a check, and they could locate their families and they could see that they could have their children, and mothers get their children back.

Some of them belong in the State hospital. They could be sent to the State hospital, and they could stay in the shelters if they wanted to stay in the shelters, if they could have more shelters available and things like that, I would like to have that.

Chairman HEINZ. Thank you. Tracey, do you want to introduce yourself?

Ms. MELLOR. My name is Tracey Mellor, and I am a mental health worker here, and these are clients of ours here.

FRED. It is an unfortunate thing that happened to me in the past years of my living as a resident of the Philadelphia, PA, area. I suffered no immediate loss to myself, but to many people I have become somewhat undesirable. They know that I have been in flight from my distant residence for 3 or 4 years now.

I live meagerly on my income as a mechanic, which is particularly tough for me here. I had no industry other than that. I had no plan to be an annoyance to the public but found myself encumbered by a situation that handicapped me to be illiterate to some extent. I found myself to be more of a plight to management than to the public.

I had lived at that residence for 15 years, at 5746 North 16th Street, raised two kids and my immediate family there, and had long suffered no intention to be a public handicap to mankind.

But thinking about the way that I was placed in a situation where I had to overcome certain circumstances in my life, I became a nuisance to people who had known me to be a very upstanding personality before that. I lived there for quite awhile with my wife, whom I married, my daughter whom I adopted, and my son by birth for quite a number of years, 15 perhaps, until they became grown kids.

I suffered no incompetence of any kind. I was not aware that mankind suffered its indignities as far as one being handicapped is concerned. They knew me to be a person of means, substantial, always afforded myself; but when I was faced with this plight, I found myself ignorant to the handicaps of the individuals who suffer it daily.

There are many people in the United States of America who suffer these handicaps, not only mentally, but substantially they do not have the amount of money necessary for them to carry on life and livelihood. They are found to be incompetent to some extent. I found them to be wholesome individuals when you get to know them. One knows one's personality by individually meeting people of a like quality. You have to do this on an immediate basis.

I know people substantially for a long period of time; therefore, I place no opinion on what I say, but what I say of them is important to them because they are the people. The people of the world make the people of any nation. They came to be friends of mine because they were illiterate, some more incompetent, some more mental previous, but I suffered no handicap by knowing them. I felt as though they were fellow worshipers. We all worshiped the God of the Heavens. We worshiped the God of the Heavens because we know God in the Heavens is the Lord God Almighty. He is there for us to maintain ourselves. We read of them and the Holy Bible. The Holy Bible is the only means of worship we have to submit ourselves to the Lord God Almighty.

I have done this always. I have always been afeared of God because God is God. To all people He is God of mankind. He serves all people who listen to him. He is the first worship we must have.

I have been of no illiterate nation. I found myself handicapped by situation of being considered incompetent. Many people have helped me to obtain what I have already obtained myself. I had nothing at all in the streets. My home was taken away from me. I was placed in prison for 90 days. I was arrested, succumbed by individuals who thought I was handicapped by my appearance No likelihood to get to know me. They know nothing about me. They just assumed by looking at me I was illiterate as I was not dressed properly.

Clothes are the making of a man. Look at a person and you see what they have on. You assume certain things about them because they reflect certain individual tastes in like or dislike. This comes about by being an individual.

I find ones that have taken the time to listen to the plight of the people, but the people rule all continents, all nations and all the world. They succumb to one individual who is the President, after him the Vice President, and on down the line. They find themselves reckoned with the duty of being normal people every day. They work, they play, they are illiterate to some station. They do things out of a sense of nature, but they are the people of the world. They assume no matter, but they make themselves known to mankind as being the people of mankind.

I realize this has happened to me because I was unemployed, detained. I was detained in my home. The police entered my home abruptly. I could not take care of the situation on my own, but one situation led to another, and they found themselves handicapped with me.

Thank you very much.

Chairman HEINZ. Fred, I am going to return to both you and Geraldine with some questions, but let me hear now from Charley.

CHARLEY. I do not know how it came to all this. It has been pretty rough. I am in and out, panhandling. When I came down, you see, I came down and did quite a bit of traveling since I have been down here, and I stayed down here during the Bicentennial, 1977, 1978, 1979, and then I left up from down here. I go for about a couple of years, I think, and came back down again and found different things going on, and I sit around watching all this.

And the other morning we came down from breakfast and we come back up, and they had to sit me up. So I stopped by the desk

and they talked to me about this, and they told me they were having a party of some kind.

Chairman HEINZ. Charley, let me ask you and the other members here, Fred and Geraldine, how long have you been homeless?

CHARLEY. I have been out now for about quite sometime, about 4 or 5 years.

Chairman HEINZ. Frank, do you know Charley? Are you familiar with him?

Mr. FERRELL. Yes, Senator, I have seen Charley many nights on the street.

Chairman HEINZ. How long do you think he has been homeless?

CHARLEY. Been since 1977 I believe.

Chairman HEINZ. Since 1977?

CHARLEY. Off and on. Off and on. You see, I had an uncle down here in Germantown, and then they closed the house down and I had to come back down.

Chairman HEINZ. Where do you usually spend the night?

CHARLEY. Right here.

Chairman HEINZ. Right here in this shelter?

CHARLEY. Yes.

Chairman HEINZ. And that has been every night or off and on?

CHARLEY. It has been about every night.

Chairman HEINZ. Just about every night since 1977?

CHARLEY. No, no. I had left from down here, you see. I was living up in Germantown, living in a private home, boarding house. I had stayed up there until, I think it was, the winter before last I came down.

Chairman HEINZ. Fred, how long have you been homeless now?

FRED. Three and a half years.

Chairman HEINZ. I gather you had a home but you lost it because of some kind of problem or incident.

Can you tell us a little bit more about what happened?

FRED. I did not lose my home. It was taken from me by the mortgage company. It is in the name of my wife, and I was told I could have access to the home, they would open the doors. The locks have been changed and I do not have the key to it.

Chairman HEINZ. So you are just out on the street?

FRED. Yes, I am out on the street because I cannot get in the home. Someone has to open it from the mortgage company.

Chairman HEINZ. Do you spend the night here?

FRED. Yes, I have spent the last few nights here, but I am not permanent—I stay at several shelters. One shelter I stayed at, they let me go because of the Campbell's soup. I thought the cans should be retained. They said it should be disposed of, and I kept a few cans and they were displeased because I kept a few cans. I was up on Chelten Avenue. They did this to me.

Another let me go because I was sick and I was in bed and I could not get up. They wanted me out because no one should be there sick. That was the situation.

Proper organization is supposed to be taking care of mankind. When you are sick, you are sick.

Chairman HEINZ. Have you ever had to sleep on the streets?

FRED. Before this, sir, no, I never slept on the street. All in a bed, a home of some type.

Chairman HEINZ. Geraldine.

GERALDINE. Ever since I have been 19 years of age, and I am 37 now.

Chairman HEINZ. Since you were 19?

GERALDINE. Yes; since I have been 19 I be on the streets. I left home to marry some guy and I went and packed my suitcase. My foster parents tried to stop me. I went out anyway with the suitcase. They said they did not want no white fellow coming in their home trying to marry their daughter. So I left, and I left with him. He drove me out to my foster grandmother. She let me stay there. I never saw the guy again. He never came back.

I stayed with her for awhile, but it has been all that time.

Chairman HEINZ. How long have you been in Philadelphia?

GERALDINE. All my life since I was 2 years old. I was born in Birmingham. The records say New York, but I was not born in New York.

Chairman HEINZ. Before the last 2 or 3 years, where have you slept?

GERALDINE. Right in this shelter, last on and off 3 years now. I got married, but that did not help none either because he is poorer than I am, the man I married. He is so poor it is a shame. He does not get nothing from nobody. Nobody likes him either. I am the only friend he has. He is very nice, but he don't get no checks. Nobody won't even lend that man $20 and me either, and I get a check, and I cannot even borrow $20 or $10, I never could.

Chairman HEINZ. I gather you have tried to get a job.

GERALDINE. They will hire me, but they will fire me. I am not eligible for work. I am only eligible for SSI. I can never work again. I am totally disabled. My mind is not going to stay on my work and I am too slow, and they are going to fire me. They got better people equipped for jobs, a lot of better people.

It is a shame. I am happy to get my check, but I wish there was about $1,500 a month. If it was $1,500 a month, or $1,800 a month, I could live comfortably. And I only want a furnished room, a tiled private bath. I want one room and one bath and I will be very happy. And my children. I want my children.

Chairman HEINZ. In the last couple of years, have you actively been looking for work?

GERALDINE. No; I cannot work. No.

Chairman HEINZ. Why can you not work?

GERALDINE. I am too slow and I cannot keep my mind on work. They are going to hire me but I am going to get fired. I used to work when I was 20, 21. I used to be a nurse assistant at Philadelphia General and University of Pennsylvania. I worked there. I had three hospital jobs and I lost them all. I was too slow so I got fired.

I tried to cheat on the TR's and I got caught. My supervisor caught me. I used to work from 3 to 12, the second shift, and at Germantown Hospital on the Cardiac Division with heart patients. I used to change a colostomy, change IV bottles, change beds and empty bed pans, give Fleet enemas. They taught me for 6 weeks. I got 82 on my exam, but I am not eligible for work ever again. Just the checks. That is all I want is my check, and I wish my husband

would stop borrowing money from me because I do not have it no more. The check is only $300 a month.

Chairman HEINZ. Charley, have you ever been hospitalized? Have you ever been sick? Have you ever needed medical care?

CHARLEY. Yeah, I had a mishap that happened outside here and I had to go down to Thomas Jefferson Hospital. I stayed there for about a month and a half, something like that.

Chairman HEINZ. A month and a half?

CHARLEY. Yes; about a month and a half or a month.

Chairman HEINZ. What was the nature of that problem?

CHARLEY. A stab wound. It happened right outside here.

Chairman HEINZ. Right out here?

CHARLEY. Yes.

Chairman HEINZ. Had you ever needed any medical care before that?

CHARLEY. No; up until then, I was all right, in good shape.

Chairman HEINZ. Fred, what about yourself? Have you ever needed any medical care? Have you visited any hospitals? Have you been able to get any medical care?

FRED. No; nothing of a medical nature. I went to a hospital because I lost my memory some years ago, but they misdirected me. I lost my memory, and when I got my memory back, I was placed in a mental ward. I was not a mental patient, but they placed me in a mental ward, and people assumed I was mentally defective.

Something is very bad in the state of being, you know, one's self. People assume you are a certain way and it is hard to get them to admit it to you, but they assume you a certain way. It is hard to overcome it. I was declared sane, but it took 4 or 5 years.

Chairman HEINZ. When was that? How long ago?

FRED. Sometime in the seventies I would say. I do not know. In the seventies.

Chairman HEINZ. Tracey or Ronald, do you have any additional information that would be useful to us on any of the situations that Charley or Fred or Geraldine find themselves in?

Mr. COMER. I have a prepared statement.

Chairman HEINZ. Do you have a prepared statement? Why do you not, Ron, please proceed with your prepared statement, if you would?

Mr. COMER. My name is Ronald Comer, and I am representing the Philadelphia Advocates for the Mentally Disabled.

Like many other mental health professionals, community outreach and shelter workers, family members and conscientious adults, we have been deeply troubled by the lack of appropriate and adequate resources needed to provide stability in residential settings for the mentally ill who have become chronically homeless. You have heard testimony from people who are homeless today about the need for finding stability in residential settings.

Recent estimates of the number of mentally ill homeless persons just in the Philadelphia center city area alone range between 600 and 800; and if other neighborhoods throughout Philadelphia are included, the count easily moves up to between 2,000 and 3,000. Many of these people are forgotten and are not counted because they are living in abandoned houses and they are living down alleys and they are trying to take care of themselves, and the only

way they know how to is by keeping out of the way. And it becomes very difficult, and it takes an effort to go out and try to find them and to know where they are. But they are out there.

The so-called safety net is simply inadequate to meet the needs of these persons. Outreach workers who face chronically homeless individuals daily on the streets and in shelters know that it is a myth that seriously mentally ill persons can pull themselves up by their own bootstraps. It is also a myth that voluntary efforts from the private sector can contribute enough assistance to fill in the tremendous gap in mental health and human services that have been created in the wake of steadily retreating Federal financial and program funding assistance.

If we are to pursue a policy based on the goal of helping chronically homeless, seriously mentally ill persons to achieve long-term stability in community-based residential settings, then we must develop the means to do two things simultaneously. We must provide long-term housing opportunities and, at the same time, insure that supporting mental health treatment services are tied into housing initiatives.

We suggest that the first of these planning imperatives be given long overdue attention through legislation which mandates that when States submit plans for the use of HUD housing dollars, the impact of those housing plans on specifically assessed long-term housing needs of the chronically mentally disabled must be included.

The mentally disabled should receive at least the same consideration in low-income housing plans as that now accorded to the physically disabled under the Federal Rehabilitation Act, section 508.

In 1977, the need for cooperation between various departments at the Federal, State and local levels to resolve the problem in successfully returning chronically mentally ill persons to the community was becoming an accepted operating principle. The Departments of Housing and Urban Development and Health and Human Services used to work together with States and local governments to implement creative approaches such as waivers that would allow States to use Medicaid funds to link supported mental health care services with housing alternatives. Such planning relationships are sorely needed now more than ever.

Therefore, our second recommendation is that Senator Heinz work to establish a commission that would see as its primary task the establishment of new working relationships between Federal, State and local government agencies in developing creative approaches to long-term housing and supportive mental health treatment programs. Local planning efforts cannot be translated into real opportunities for developing stable, long-term community residential settings for homeless, chronically mentally ill people until everyone who should be involved is involved.

I want to conclude by expressing our gratitude to Senator Heinz for his concern and his leadership in initiating this important opportunity to address a national tragedy that must no longer be ignored.

Thank you. [Applause.]

[The prepared statement of Mr. Comer follows:]

PREPARED STATEMENT OF RONALD C. COMER

My name is Ronald Comer, I am representing the Philadelphia Advocates for the Mentally Disabled. Like many other groups of mental health professionals, community outreach and shelter workers, family members and conscientious adults, we have been deeply troubled by the lack of appropriate and adequate resources needed to provide stability in residential settings for seriously mentally ill persons who have become chronically homeless.

Recent estimates of the number of chronically mentally ill homeless persons, just in Philadelphia's center city area alone, range between 600 and 800. If other neighborhoods throughout Philadephia are included, the count easily moves up to between 2,000 and 3,000.

The only published expert opinion on the percentage of chronically homeless persons in Philadelphia, who are also chronically mentally ill, is one authored by A. Anthony Arce, M.D., Stuart Shapiro, M.D., et al. Their study, reported in the September 1983 issue of Hospital and Community Psychiatry, of a sample of 193 homeless persons suggests that if only those who are regularly or continuously living on the streets are considered, physicians could expect to make a diagnosis of schizophrenia in nearly 50 percent of the people they would see. Another 16 percent would be diagnosed as suffering from other types of seriously disabling mental illnesses, including organic brain syndrome, major depression, and other psychotic illnesses. Alcohol and mixed substance abuse would be the primary or secondary diagnosis in 33 percent of those who reside continuously on the streets of Philadelphia. These figures are generally consistent with expert opinions provided from other cities throughout the United States.

In planning for the general emergency shelter needs of its homeless population, Philadelphia city government has acknowledged the importance of specialized shelter services to meet the needs of those among the homeless who are chronically mentally ill, and those who are chronic alcohol and substance abusers. Several hundred shelter beds have been opened during the past 3 years for Philadelphia's homeless. However, only 81 beds have been opened specifically for the mentally ill and none have been officially opened specifically for alcoholic and otherwise intoxicated homeless persons. Thirty-five of the 81 specially designated mental health care beds are in an intensive short-term psychiatric care facility where the length of stay averages about 3 weeks. As for the remaining 46 beds, which are part of this State's community residential rehabilitation facility system, fewer than 30 persons with a history of chronic homelessness have achieved residential stability; meaning they have not returned to the streets.

Put very simply, outreach efforts, shelters, and soup kitchens are working for only about 5 percent of the chronically mentally ill, chronically homeless population. That is not good enough.

Last year, community mental health centers in Philadelphia struggled to offer supportive psychiatric and rehabilitative services to former State mental hospital patients now living in the community. Philadelphia's Office of Mental Health estimates that 15,000 former State mental hospital patients have been returned to Philadelphia communities in recent years. The number of mentally ill persons actually provided any form of community mental health care fell far short of this figure. In all, less than one-third the number in need of psychiatric treatment and supportive mental health services were able to gain access to community mental health treatment services last year. The degree of unmet treatment needs in Philadelphia and elsewhere throughout the United States is absolutely deplorable.

It is the deterioration of financial support for the community mental health center movement which accounts for why so many seriously mentally ill adults are winding up in local jails and prisons and on city streets throughout the United States. Now that the indigent mentally ill have no where to turn, what did we expect would happen?

The tragic irony underlying the pathetically impoverished community mental health treatment movement is that the lion's share of public funding continues to be poured into institutional care, even as those institutions lock out the sickest of the poor for whom community-based services are totally and unequivocally inadequate. It isn't the scope of severe and urgent need represented by chronically mentally ill homeless persons that is unclear, but the intent of our public bureaucracies and government officials to begin earnest efforts aimed at redressing basic human deprivations.

The so-called "safety net" is simply inadequate to meet the needs of these persons. Outreach workers who face chronically homeless individuals daily on the streets and in shelters know it is a myth that chronically mentally ill persons can

pull themselves up by their own bootstraps. It is also a myth that voluntary efforts from the private sector can contribute enough assistance to fill in the tremendous gaps in mental health and human services that have been created in the wake of steadily retreating Federal financial and program planning assistance.

These hearings, called today by Senator Heinz, offer hope in that they represent a very vital recognition of the importance of taking a hard look at the effects recent shifts in health and human service policies at the Federal level have had on our basic human responsibility to care for indigent mentally ill people whose health and welfare is dependent upon their receiving appropriate psychiatric treatment, adequate long-term residential placements, and supportive mental health and human services.

If we are to move our success rate up from the 5 percent mark, then we must develop the means to do two things simultaneously. We must provide long-term housing opportunities and at the same time ensure that supportive mental health treatment services are tied into housing initiatives.

One essential task is to recognize that special initiatives must be developed to address this population's long-term housing needs. We should no longer assume that housing needs are being provided in the community through transitional programs and boarding homes alone because we know it isn't so. The community mental health system has basically ignored the low-income, long-term housing issue as it relates to this vulnerable population.

One way to get a handle on this planning imperative is to develop legislation which mandates that no State can submit a plan for HUD housing dollars without including specific assessments of the housing needs of the chronically mentally disabled. The mentally disabled should receive at least the same consideration in low-income housing plans as that now accorded the physically disabled under the Federal Rehabilitation Act, section 508.

In 1977, the need for cooperation between various departments at Federal, State, and local levels to resolve the problems in successfully returning chronically mentally ill persons to the community was a well-acknowledged operating principle. The Departments of Housing and Urban Development and Health and Human Services began working together to provide incentives for the development of residential alternatives and supportive services to this population through special incentive programs such as waivers that would allow states to use Medicaid funds to link supportive mental health care services with housing alternatives. Our second recommendation, therefore, is that Senator Heinz work to establish a commission that would see as its primary task the establishment of new working relationships between Federal, State, and local government agencies in developing creative approaches to long-term housing and supportive mental health treatment programs.

Such planning relationships are sorely needed now more than ever. Local planning efforts cannot be translated into real opportunities for developing stable long-term community residential settings for homeless chronically mentally ill people until everyone who must be involved is involved.

Chairman HEINZ. Ron, thank you very much. I have some questions of you but I see that Ralph has just arrived.

Ralph, thank you very much for coming. This is me over here. Thank you very much for coming.

Let me ask you where did you spend last night?

RALPH. In the neighborhood.

Chairman HEINZ. In the neighborhood. Which neighborhood?

RALPH. This neighborhood.

Chairman HEINZ. Around here?

RALPH. Right.

Chairman HEINZ. Did you sleep on the street?

RALPH. I was a little cold.

Chairman HEINZ. Do you usually sleep on the street?

RALPH. No.

Chairman HEINZ. Where do you usually sleep?

RALPH. In here.

Chairman HEINZ. I cannot hear you. I am sorry. Do you have a home that you can call your own?

RALPH. No.

Chairman HEINZ. No. How long have you been without a place you could call home?

RALPH. Quite some time.

Chairman HEINZ. I cannot hear you.

Tell me if I am wrong. It has probably been awhile since you have had a place you can call home, and you call the streets your home, do you not?

RALPH. That is the people there.

Chairman HEINZ. You feel safer in the street than you do in a shelter?

RALPH. Sometimes.

Chairman HEINZ. Yes?

RALPH. Yes.

Chairman HEINZ. So you do not come to a shelter like this to sleep unless it is very cold? Have you ever been to this shelter before?

RALPH. Once in the past. Then I stopped.

Chairman HEINZ. How old are you?

RALPH. Thirty.

Chairman HEINZ. How much of an education do you have? Did you finish high school?

RALPH. I think I did a little bit.

Chairman HEINZ. A little bit. Can you write?

RALPH. Yes.

Chairman HEINZ. Can you read all right?

RALPH. Yes.

Chairman HEINZ. Have you had any luck holding a job?

RALPH. No.

Chairman HEINZ. Can you remember when you last held a job?

RALPH. One year ago.

Chairman HEINZ. Were you able to keep it for very long?

RALPH. Yes.

Chairman HEINZ. What happened that you are not working any more?

[No response from witness.]

Chairman HEINZ. Thank you very much.

Frank, are you familiar with Ralph's case?

Mr. FERRELL. Yes, I see Ralph almost every evening on Cuthbert Street. It has been nicknamed Rat Alley, and a lot of children that get involved in my son's campaign all want to see Rat Alley. They cannot believe that there are rats running around the streets with people laying beside them.

Ralph lays next to a dumpster every night. You got yourself a little mattress there, Ralph. He is just one of the many friends that we have now.

I am here today not as an expert witness. I am just a novice. Some have referred to us as amateurs, and we admit maybe we are. We are crack fillers, and we are attempting in a small way to fill the cracks, and maybe groups in the private sector can come together a little bit and be threads to patch up some of the holes.

But Ralph is just one of many, so very many that we see every night that may never be productive citizens. But we care about them and that is all that we ask, that on their behalf concern and

compassion be shown to people who will never be able to reward us, never come back into society and perform skilled jobs.

Chairman HEINZ. Has Ralph ever been diagnosed or treated for any mental disorders?

Mr. FERRELL. Not that I know of.

Chairman HEINZ. Has he ever been to a hospital for health reasons, for examination?

Mr. FERRELL. I am sorry, I don't know.

Chairman HEINZ. Very well.

Ralph, thank you very much. I know that it is uncomfortable for you being here. You would much rather be someplace else, but I thank you very much. There are many people like you who have a terribly difficult time getting along and through no fault of their own. So I am grateful to you.

Let me ask Ron Comer this.

Ron, you made two suggestions, one that there ought to be a planning process for the States in the use of their housing and housing-related money. The other is that there should be a commission that would try to clarify the Federal, State, and local roles as well as develop, as a result of that, some creative approaches to dealing with this problem. And you note in the course of your statement that at least two changes have come about that have placed tremendous strains on people and on existing systems. One has been the change in the State commitment laws and the depopulation of State mental hospitals.

Ten, fifteen years ago, we had a population of 500,000, and now it is down to around 125,000. So two-thirds or three-quarters of the people who would have been in those institutions have been deinstitutionalized, and a lot of the people who might otherwise have been drawn in, at least temporarily, to a mental treatment system have never been drawn in as a result, in a sense, of the shutting down of that network.

Second, the Community Mental Health Centers Program, which was started back in 1963 and which was supposed to serve every catchment area in the United States, close to 2,000, as I recollect, never was really completed. Only at a peak, in 1974 or 1975, were centers established in 700 of those catchment areas. Here in Pennsylvania we did a relatively good job of making use of that program, but that was a program that once started by Federal initiative had declining levels of Federal support, and that Federal support for those community mental health centers has now ended.

The notion was that the social services block grant to the States, and I assume probably such initiatives as general revenue sharing to the States would help the local community pick up the slack in developing their own funding streams. Apparently all the progress that we made has kind of slipped backward.

What is the status, as you see it, of the community mental health network? Is it declining? Is it struggling and holding its own, or what is happening to it here in Pennsylvania, for example?

Mr. COMER. I think what is happening to it, certainly here in Philadelphia and I would imagine throughout the State, but in the large metropolitan areas like Philadelphia where the tax base is eroding and there are struggles to meet a lot of the fiscal demands the city has in a lot of different areas, holding onto the mental

health centers and keeping them operating at full capacity to meet many varied needs has not been possible. And there has been in this city efforts to consolidate the Community Health Centers Program and to take a look at how to restructure the system, and all too often this restructuring of the system tends to serve more the survival of the system, more so than it does the survival of people who must depend upon that system for the kinds of support in the community that they need if they are going to live decent lives, and that is the problem that we have seen here.

We have seen the fact that if a person can get into a hospital, can receive some treatment and some medication to help bring back their memory, to help bring back their ability to begin coping with some of their mental illness, because of the policies of the institutionalization, which I think most of us believe are focused on a very valuable principle in terms of people trying to live normal lives in the community as much as possible, they are going to be discharged back into the community. When they get back into the community, the problem is there are not the resources there to give them the support they need. There is no long-term housing. There is only transitional housing, and in Philadelphia the transitional housing program which is called community residential rehabilitation facilities have been far too slow in developing. They are still less than at a halfway mark of the need that was assessed in 1981 for a number of those facilities that were needed.

Such programs as social rehabilitation programs and vocational rehabilitation programs, outpatient day hospitalization programs, when you compare the estimate of need based upon conservative estimates with what is actually provided, there are great disparities, and so we are not just talking about cracks in the system. In reality, these are huge gaps in the system through which people who are the most seriously ill find the least amount of support, and we are talking about publicly dependent individuals. That means they must depend upon programs that were established by the Federal Government, such as Supplemental Security Income, Medicaid and Medicare for their medical and social needs.

Those programs—the irony of this whole business is that those programs still go to fund principally care in institutional settings, but because of cost containment measures that we have all been experiencing over the last 5 to 6 years intensively, those institutional programs are even being cut back. So that now that door is slammed shut with no kind of funding mechanisms in place to support the variety of community-based services that are so badly needed.

Even if we had long-term housing instead of transitional housing, which we do not, and it is all based upon this notion that people are going to achieve independent functioning levels in the community because that was behind the community mental health centers in 1963, that we would move toward independent functioning, the fact of the matter is that some people may never move toward independent functioning. They will always need some form of support in place to help provide them with stability that they need to live decent lives in community-based residences.

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We do not have the mechanisms. We have not developed the mechanisms at the Federal, State, or the local level to provide those kinds of programs and the funding they need.

Chairman HEINZ. Ron, in my opening statement I made the distinction between relatively short-term homeless, the people who were temporarily down on their luck and had lost their jobs, for example, and the other population of long-term homeless, a substantial number who have mental impairments or suffer from mental illness.

Is that the group of people which is growing, the latter group?

Mr. COMER. I think there is every indication to support the belief that that population is growing: Here in Philadelphia people who are most closely associated with planning for the needs of people who have been chronically homeless recognize that the problem is growing. They also recognize that there has been absolutely no significant inroads made toward stabilizing chronically homeless people. There have been small gains made. There have been gains made in providing shelters by the private sector into which people can remain for long periods of time, for months and sometimes even years.

The problem is that we are talking about a handful of beds at that level. The public system is trying to keep up with the emergency services system in terms of trying to assure that people that are out on the streets are going to have a place to come to when the elements become so unbearable that their life is threatened. But in terms of achieving any real inroads toward the goal of stability in residential settings for the chronically homeless, that has not really been occurring yet and we are going to have this problem nationwide and not just in Philadelphia for many years to come until we start looking at the policies that we are making and how they impact on this problem either positively or negatively.

Chairman HEINZ. Let me ask you about what kind of catchment system we have for mentally ill homeless people. How are homeless people first likely to be identified? Does somebody go out on the streets and say, hello, how long have you been sleeping there, or do they end up being arrested and in jail, or where do we first learn about the people who have these kind of difficulties as individuals?

Mr. COMER. There are two different kinds of outreach that are occurring right now. One outreach effort is that which has been initiated through the efforts of private groups such as the Mercy Hospice and by people such as Trevor's Campaign, by an individual named Eisenhut who, over 10 years, has been seeking out the mentally disabled on the streets of New York and Philadelphia, and by a group called the Philadelphia Committee for the Homeless which began distributing blankets and food and trying to identify those individuals who would come in. Their primary goal is to try to identify those individuals who will come in off the streets and try to help get them to shelters. Their hope then is once they are out of those shelters, they will be provided the assistance that they need, financial supports and placements into existing residential facilities in the community, some sort of stability so they will not return to the streets.

They know this is not true though, that they do return to the streets on a continual process.

The other outreach effort is the effort that has been initiated recently by the city of Philadelphia through its Department of Health and through its Department of Public Welfare. Again, the effort is to try to get those people who will come in off the streets to come in.

Chairman HEINZ. Are any of these individuals ever intercepted by the police and end up in jail?

Mr. COMER. Many times. In fact, one of the largest inpatient providers for the publicly dependent, mentally ill is Holmsburg Prison at which there are approximately 150 beds in three different blocks. Many of the people that are housed in the jails of this community in the way that they were in the early Colonial America are there for no other reason than the fact that they have not been able to receive appropriate treatment in the community and they were unable to return to the State hospital. They were unable, in other words, to return to appropriate levels of treatment in order to begin this whole process of community-based services once again. So they are now housed in jails.

Chairman HEINZ. One last question and I think we can excuse everybody on the panel.

With respect to the elderly, are there many elderly homeless, and if so, what proportion of them would also suffer from mental disabilities of one kind or another?

Mr. COMER. I would like to have Tracey, who has been working in the Drop-In Shelter, answer that question, if I may, because she has been here and she has seen the people coming in. She is just one of the people who have seen it. You are going to have to multiply what she says to you by at least tenfold because there would be that many other people from other shelters here who could also tell you about their experiences.

Chairman HEINZ. Tracey, in your experience are there many elderly homeless, and if so, what proportion of them suffer from mental problems of one kind or another?

Ms. MELLOR. The best way for me to answer that, Senator, would be to tell you that I basically come in contact here only with the mentally ill because that is my role and function. I would say about 5 percent of the people with whom I work are elderly, up into 60. Another large group is above the age of 45. Many are infirm physically and mentally just from being on the streets. They cannot fight the elements as well, but that does not really represent—I would say it is probably a greater percentage in terms of an overall total. We see about 70 percent of the clients here as mentally infirm.

Chairman HEINZ. Among the elderly, are they in the classic mental illness categories of schizophrenia, manic depressives, or are they suffering from other diseases, such as Alzheimer's disease?

Ms. MELLOR. I think more would fit in the organic category, Alzheimer's, but there are many who are chronically schizophrenic and have maybe lived 20 to 30 years in Philadelphia State Hospital, but they were dropped from the institutional setting.

Chairman HEINZ. What you and Ron and the rest of the panel have helped us understand is that there is a long-term problem here that is really the tip of the iceberg. It is not going to go away and melt away. It is likely to get somewhat worse than somewhat

better, simply because there is an inadequate mental health care system at the present time and the pressure is still to be institutionalized without any countervailing method of keeping track of people.

Ms. MELLOR. Right.

Chairman HEINZ. Back in 1973 or 1974 when we thought we were doing a pretty good job in Allegheny County, my home county, I know we lost track of people in MHMR, the Mental Health-Mental Retardation System, and it was dramatized one day when someone who had actually been in an institution and been under a lot of care moved from one catchment area to another, lost track of any casework management, and ended up committing suicide. That is probably not as infrequent as we would like to believe, and I am sure there are substantial numbers of people who, as George Johnson, did, die on the streets of Philadelphia. That is rare but not infrequent.

Do you agree with that?

Mr. COMER. Absolutely.

Chairman HEINZ. I want to thank you all for your kindness, your patience, your understanding and being here. We appreciate your service. It is indeed a service to the country. Thank you very much. [Applause.]

[Whereupon a short recess was taken.]

Chairman HEINZ. At this time we would like to welcome our second panel which consists of Dr. John A. Talbott, president, American Psychiatric Association: Dr. Harvey Vieth, Chairman, Federal Interagency Task Force on Food and Shelter for the Homeless, Department of Health and Human Services; Leo Brooks, managing director, city of Philadelphia; and Sister Kathleen Schneider, administrator, Mercy Hospice, here in Philadelphia.

We are pleased that you could join us today.

Dr. Talbott, I understand you have a prepared statement which you would like to give. Please proceed.

STATEMENT OF DR. JOHN A. TALBOTT, NEW YORK, NY, PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. TALBOTT. I am John A. Talbott, M.D., president of the American Psychiatric Association, professor of psychiatry at the Cornell University Medical College and associate medical director of the Payne Whitney Psychiatric Clinic of the New York Hospital in New York City.

The American Psychiatric Association, a medical specialty society representing over 30,000 psychiatrists nationwide, appreciates the opportunity to testify before the Senate Special Committee on Aging to provide our views on the genesis of homelessness, including those public policy failures which can be identified as contributory, and our recommendations for new public policy directions in meeting the needs of the myriad of individuals whom we have come to refer to simply as "the homeless."

We are particularly proud that the APA has been in the forefront of increasing involvement and concern by the medical profession about this issue. There was a sense of urgency when we formed our task force on the homeless mentally ill just over a year

ago. The problem was of such magnitude, the plight of the homeless so desperate, that the task force was asked to complete its report and recommendations within a year. Charged to gather all the research, data and knowledge available, to prepare a substantive volume containing an up-to-date summary of what is known about the problems of the homeless mentally ill, and to formulate recommendations to deal with these problems, the task force met its deadline, and our report was presented to the public in mid-September.

Let me summarize some points first and I will then proceed to make our recommendations on this subject.

We are aware that homelessness is not a new phenomenon. Certainly there have been homeless people since colonial times. What is new is the number and percentage of seriously and chronically mentally ill persons among the homeless, a percentage and a number have increased dramatically in recent years, and a population with very different needs from the rest of the homeless. As you pointed out in your opening statement, the homeless cannot be seen as a homogeneous population.

Estimates vary about the number of homeless people who have serious and chronic mental illness. However, if it is anywhere near 50 percent, and certainly that is likely, a large number of those have very severe illness: schizophrenia, manic depressive illnesses, and the like.

While the incidence of homeless mentally ill has increased, we do not believe that deinstitutionalization per se can be blamed. Deinstitutionalization has helped many people, but has harmed some because it was carried out naively, without the provision of adequate community settings or adequate community services. The State hospitals that provided all the services under one roof, for better or for worse, had responsibility for the people and provided comprehensive services. When those people moved out into the community, the services, the settings, the responsible organizations, did not move with them.

Another important building block on which our recommendations are founded is the fact that society has not resolved its ambivalence between keeping the mentally ill out of sight and opposing involuntary commitment. I do not think that society can have it both ways any longer.

Currently, there are too few States that give family members easy access to prompt treatment for mentally ill relatives. Another very important point to stress is that the current emphasis on shelter alone deflects, as you have pointed out, from long-term solutions. If all we do is look at the necessary, but insufficient, immediate step of shelters, we are going to miss out on comprehensive solutions to the entire problem.

The overreaching recommendation of our report is that we need to move toward what was thought in the 1950's by the World Health Organization, in the 1960's by the Kennedy CHMC legislation to be a comprehensive and integrated system of care, that we still have not achieved in this country. This has to be a primary goal of any move in the mental health field in the next decade or two.

Our major recommendation has been broken down into a number of smaller recommendations. I will highlight each of them. I should emphasize that they all need to be taken as a package. A piecemeal approach will merely exaggerate the crazy quilt of services we have now. To meet the complex needs of the homeless mentally ill we must take all of these into consideration.

Certainly, we need to provide for basic needs: Shelter, food, clothing, and so forth. But we also need a series of graded living settings, including everything from intensive care units, quarterway or halfway houses, lodges and camps, boarding care homes, satellite housing, foster and family care, and crisis housing in temporary hotels.

When we speak of the homeless mentally ill, we are talking about people who for the most part cannot make decisions, cannot organize themselves in such a way that access to mainstream housing is an alternative. These are people who cannot use mainstream housing. They need some level of supervision.

Dr. TALBOTT. We feel that psychiatric and rehabilitative services must be available and must be assertively provided through outreach services. We know, for instance, that the very seriously and chronically mentally ill have three times the amount of medical illness that their age peers have. Therefore, medical care has to be available. Crisis services have to be available because, just as everyone else, the chronically ill have acute episodes of illness.

One of the most important recommendations has to do with responsibility in moving from that single point of responsibility, the State hospital. Again, for better or for worse, in the last 30 years we have lost responsibility for the population of the deinstitutionalized for subgroups and for individual persons, and that responsibility has to be reestablished.

There are a number of models for that. Certainly the case management, community support system model of the Mental Health Systems Act was one of those and a good model. We also feel there have to be changes in the legal and administrative procedures by which mental health services are provided that involve ease of conservatorship that involve involuntary commitment laws that are more humane, that involve the provision of outpatient civil commitment.

Finally, advocacy efforts have to be really refocused on providing care rather than a focus merely on freedom.

Another point has to do with the provision by the society of some form of asylum, sanctuary, continuing care. We have lost that essential ingredient needed for a very small percentage of the population, maybe 2 percent, maybe 3 percent. The number of people requiring such care is not large, but we have no funding mechanism to provide it.

We also have not yet arrived at a coordinated system of funding for mental health services in moving from one single setting to a diversity of settings.

In addition, we are aware that social services need to be provided and adequate training of people needs to be provided, that there is a need for more and better research, more and better epidemiological data. And the bottom line for all of this is our understanding

that these solutions will not come about without the addition of new moneys.

In moving forward from an institutional-based system to a multiplicity of resources, we have gotten about halfway there. It will require double funding for a period of time before we get all the way there. The recommendations I have cited will have to be funded by expenditures of funds at the Federal, the State, and the local level.

Mr. Chairman, the APA would be more than happy to work with you and your committee to draft meaningful long-term solutions to the problems of the homeless mentally ill. We have seen our joint efforts in the past come to fruition in the passage, after almost 3 years, of the omnibus Social Security disability insurance legislation, and we know our mutual commitment involving this issue will also be productive.

Thank you very much.

Senator HEINZ. Dr. Talbott, thank you very much.

Your full statement will be placed in the record.

[The prepared statement of Dr. Talbott follows:]

PREPARED STATEMENT OF DR. JOHN A. TALBOTT

Mr. Chairman, members of the committee, I am John A. Talbott, M.D., president of the American Psychiatric Association and professor of psychiatry at the Cornell University Medical College and associate medical director of the Payne Whitney Psychiatric Clinic of the New York Hospital in New York City.

The American Psychiatric Association, a medical specialty society representing over 30,000 psychiatrists nationwide, appreciates the opportunity to testify before the Senate Special Committee on Aging to provide our views on the genesis of homelessness including those public policy failures which can be identified as contributory, and our recommendations for new public policy directions in meeting the needs of those myriad of individuals who we have come to refer to simply as "the homeless."

We are particularly proud that the APA has been in the forefront of increasing involvement and concern by the medical profession about this issue. There was a sense of urgency when we formed our Task Force on the Homeless Mentally Ill just over a year ago. The problem was of such magnitude, the plight of the homeless so desperate, that the Task Force was asked to complete its report and recommendations within a year. Charged to gather all the research, data and knowledge available, to prepare a substantive volume containing an up-to-date summary of what is known about the problems of the homeless mentally ill, and to formulate recommendations to deal with these problems, the Task Force met its deadline, and our report—and I am honored to present you with a copy—was presented to the public in mid-September. The report contains a series of key public policy recommendations for the management of the population of homeless mentally ill. Such recommendations were based not only upon the expertise of the members of the Task Force, among whom were leading experts in the field, many of whose individual efforts were pioneering ones, but upon the data amassed through a series of site visits to shelters and other programs seeking to serve the needs of the mentally ill homeless across the country.

The recommendations form the basis for the legislative and other Federal, State, and local activities which must occur if we are to resolve this problem on a long-term rather than palliative, short-term basis. They also form the basis for a recently agreed upon collaboration with the American Medical Association to help broaden the base of concern and activity in this regard. It is the work of this Task Force upon which I am drawing in my prepared statement today, and they are the recommendations of this Task Force which I will be proposing in both their generic and somewhat more operational forms later in this presentation.

Before discussing these recommendations, I would like to summarize a number of the major points of the Task Force's study of the homeless mentally ill in America, because it is only within the context of what we know about this population, that specific, appropriate remedies can be crafted.

Homeless in America is not a new phenomenon.—Colonial documents reveal the existence of wanderers; indeed, almshouses, workhouses, and poorhouses were estab-

lished partly to serve those without adequate housing. More recently, particularly during the Great Depression of the 1930's, vagabonds and hoboes were common in both urban and rural areas. For years, skid rows have served as a refuge for many of those living on the margins of society—the so-called derelict or chronic alcoholic.

Today, the rapidly growing problem of the homeless has emerged as a major societal tragedy, commanding increasing attention from all segments of society, the media, government, private organizations, and the public at large. The homeless have crept from the skid rows, from the almshouses, from the hidden alleys of the past, to place themselves squarely in front of us: In our parks, on our major streets, indeed, in front of our very homes and places of employment. By some, those affected by homelessness are regarded as a detrimental part of the cityscape, an eyesore to be eliminated, bag ladies and grate gentlemen to be pitied and hurried past. However, by others they are seen as victims of a moral scandal with roots reaching from family, community and caregivers to the highest circles of government.

A marked proportion of the homeless are also chronically mentally ill, characterized by different constellations of needs and responded to differently than others among the homeless.—While the media have documented the problems of the homeless in general, until relatively recently, there has been little attention paid to a very special subgroup within this homeless population—a subgroup whose ranks have been estimated to constitute as much as 50 percent of the homeless—the homeless mentally ill. Arce and his colleagues, for example, in 1983, determined the prevalence of mental illness among 193 homeless men and women brought to an emergency shelter in this city in December 1981. A subsample of 179 received psychiatric evaluations, and 40 percent were found to have major mental disorders. The leading primary diagnoses were schizophrenia for more than one-third of the cases, and substance abuse for one-fourth. Secondary diagnoses of substance abuse were made for an additional 18 percent. Baxter and Hopper's 1981 field study, updated a year later, assessed mental disability and service needs among the homeless on New York City streets. These landmark studies provided vivid descriptions of the homeless population and suggested that as many as half may suffer from serious psychiatric disorders.

While we have all been appalled by the study findings bearing out the surprising numbers of homeless who are characterized as mentally ill, we have until recently lacked the knowledge of who they are, how ill and disabled they are, what their needs are (in terms of shelter, psychiatric treatment, other medical treatment and social and support services), and what sort of plan or plans can ameliorate their plight on both a short and longer term basis.

When we look at the homeless mentally ill, we are really dealing with two problems with multiple causes and subgroups: homelessness and chronic mental illnesses. Each in and of itself is a formidable challenge to resolve, but combined, they present a problem of unprecedented magnitude and complexity. Neither concept has been well defined for the purposes of research. Neither concept has been well defined for the purpose of rendering public policy decisions regarding their prevalence in the population or how to meet the needs of individuals characterized either as chronically mentally ill or homeless. Neither concept has been well defined for greater ease in integrating persons in either category into existing habilitation, support or medical care networks. As Irene Shifren Levine points out in our Task Force report: "There are relatively few service programs that have been specifically developed to meet the needs of the homeless mentally ill. In fact, the population bears the cross of a dual disenfranchisement from society and its agents of service delivery: the mentally ill are often excluded from programs designed to serve the homeless, and those who are homeless are typically screened out from receiving services designed for the chronically mentally ill."

Thus, the homeless mentally ill have become our society's "untouchables," unable to advocate for themselves, unable to protect themselves from harm, unable to acquire the bare necessities of living. Of the homeless, they are perhaps the most vulnerable, the most disturbing to the public and the least likely to receive any help. They are a frightening specter of what could become of any one of us, because mental illness is democratic: it knows no economic class, no ethnic or racial background, no gender. Its devastating effects can drain family resources, destroy family cohesion—can lead the mentally ill away from their homes, from treatment, from the very persons and elements which could help in remission or recovery.

While the incidence of homelessness among the mentally ill has markedly increased over the past three decades, coinciding with the deinstitutionalization movement, deinstitutionalization itself cannot be blamed for the situation, nor was it bad per se.—The concept of "asylum" has been with us over myriad years. Refugees have sought asylum on our shores for hundreds of years, seeking a safe haven in

which to conduct their lives. Defectors seek asylum from political repression. Asylums were created for the mentally ill for a two-fold purpose: first to protect them from a society in which they did not "fit" and later to protect society from those they had before benignly sought to shelter.

By the mid-1950's, large, often State facilities for the mentally ill—asylums—became the focal point of a major shift in public policy. As Richard Lamb, M.D., chair of the Task Force on the Homeless Mentally Ill pointed out in his chapter of our report, "When the new psychoactive medications appeared along with a new philosophy of social treatment, the great majority of the chronic psychotic population was left in a State hospital environment that was now clearly unnecessary and even inappropriate for them, though it met many needs. * * * Another powerful motivating force was concern about the civil rights of psychiatric patients (including issues surrounding competency and involuntary commitment). * * * Not the least of the motivating factors was financial. State governments wished to shift some of the fiscal burden for these patients to Federal and local government—that is, to Federal SSI and Medicaid and local law enforcement agencies and emergency health and mental health services." (Parentheses added.)

This constellation of public policy changes led to the wholesale "deinstitutionalization" of many of the chronically mentally ill. The dimensions of the phenomenon of deinstitutionalization are revealed by the numbers. In 1955, there were 559,000 patients in State hospitals in the United States; today, at any given time, there are approximately 123,000. Conceptually, deinstitutionalization was not flawed; its implementation was.

With the advantage of hindsight, we can see that the era of deinstitutionalization was ushered in with much naivete and many simplistic notions about what would become of the chronically and severely mentally ill. As noted above, the importance of psychoactive medication and a stable source of financial support was perceived, but the importance of developing such fundamental resources as supportive living arrangements was not clearly seen or implemented. The concept of community treatment was much discussed, but there were no clear idea as to what it should consist of, and the resistance of community mental health centers and other more traditional providers of both treatment and social and environmental support services was not anticipated. Nor was it foreseen how reluctant many States would be to allocate funds for community-based services.

In the State hospitals what treatment and services that did exist were in one place and under one administration. In the community, the situation is very different. Services and treatment are under various administrative jurisdictions and in various locations. Even the mentally healthy have difficulty dealing with the number of bureaucracies, both governmental and private, to have their needs met. Further, patients can easily get lost in the community as compared to the hospital. Imperfectly conceived, deinstitutionalization has led to a situation in which those who have been released from the hospital have fallen between the cracks of the community's social and health service networks. In a sense, the refugees from yesterday's locked wards have become the tragedy of the inhabitants of our back alleys. Their asylum—their safe haven—has been lost.

Since the time of mass deinstitutionalization in the 1950's and 1960's, however, other individuals, chronically mentally ill, whose histories have been vastly different from those who were deinstitutionalized in the early days of the movement, also have entered the system or nonsystem of the homeless. They have become the victims of the same absent or if not absent, then cumbersome and labyrith-like community network, and have not received basic service needs. In the main, this population is younger, more involved with drugs and alcohol, more disruptive, and with a history of short-term, rather than long-term hospitalization, based in part upon commitment law changes brought about at the same time as the deinstitutionalization movement. Their lack of shelter is similar to that of those older homeless mentally ill now inhabiting our streets, but their medical, social and other support service needs are vastly different.

Society's ambivalence about wanting the mentally ill kept out of sight, while at the same time opposing involuntary commitment, must be better resolved.—Almost immediately after deinstitutionalization occurred, society reacted vehemently to their presence on our cities' streets. Yet society has increasingly rejected the idea of remanding some of these most seriously and chronically ill patients to state hospitals for long periods of time. Currently, few states have commitment laws that give family members or those responsible for treatment easy access to prompt treatment for persons whose mental illness has worsened or whose condition has deteriorated severely. Society cannot afford to have it both ways, particularly when today's hospitals are required to undertake "active treatment" for those still within the walls

of such facilities, and the streets, single room occupancy dwellings, and other extant community living arrangements fail to provide any treatment at all. For many of the mentally ill homeless, the community has become the snakepit that was the institution of the past—absent psychiatric and other medical care, absent adequate sanitation, absent human contact and other social support services.

The emphasis on homelessness or lack of shelter per se has deflected attention from the basic, underlying problem of the lack of a comprehensive support system for the severely and chronically mentally ill.—The problems confronting the mentally ill homeless over time have been exacerbated by a number of factors: the failure of psychiatry and other medical professions to know how to address the problem; the reluctance of nonmedical social service personnel to work with this population; the victims' own suspiciousness of authority and mental health professionals and their inability or unwillingness to form interpersonal relationships as well as their mental disability; the denial of mental illness as a medical disorder endemic in the homeless population which, as other medical conditions, requires care and treatment; and perhaps most important, the fragmentation of responsibility for the population among a labyrinth of agencies whose funding, administration, and monitoring cut across health, housing and human service agencies, across layers of government and across the public and private sectors, leading to a disorganized nonsystem of service that is highly inconsistent in appropriateness, availability, acceptability and quality.

The APA's Task Force, and the APA itself, have recommended that to address the problems of the homeless mentally ill in America, a "comprehensive and integrated system of care for this vulnerable population of the mentally ill, with designated responsibility, with accountability and with adequate fiscal resources, must be established." The intent, however, is not to deal solely with those who are now on the streets, but to ensure that such a system of care exists for those whose severe and chronic mental illnesses require treatment which a facility is no longer able to provide as the result of commitment laws which prohibit long-term hospitalization. We must not only establish a program for the homeless, but ensure that we do not fail to meet the needs of those for whom the streets would become their only recourse in the future, absent such services.

Our major recommendation has been broken down into 14 derivative recommendations. As I discuss each in turn, I hope to provide some operational recommendations which could serve as the basis for legislative action on each. The committee should bear in mind, however, that these recommendations are in essence, a complete package. A piecemeal approach would only add to the current crazyquilt of programs which exist, but which have failed in their conception and conduct to meet the needs of the homeless mentally ill in the past, today, and, though we have not, in the future.

Any attempt to address the problems of the homeless mentally ill must begin with provisions for meeting their basic needs: food, shelter and clothing.—The chronically mentally ill have a right, equal to that of other groups, to these needs being met. Outreach to these individuals is much more difficult, as the result of their illness itself. Self identification of the homeless mentally ill is virtually nonexistent—they simply do not come forward for help, some out of fear that they will merely be rehospitalized, some out of fears native to their illness itself, some because they do not believe they need help. Just as Congress has required that special emphasis in the alcohol, drug abuse and mental health block grants be placed on the chronically mentally ill, just as Congress has placed special emphasis on research into causes of chronic, severe forms of mental illness, just as Congress has emphasized training in the treatment of the chronically mentally ill for physicians and other mental health practitioners, so, too, must Congress create a legislative theme that ensures whatever or whenever legislative basic rights or service are established or provide for the care of the homeless, that such legislation mandate that a priority be effectuated on behalf of the special needs of the homeless mentally ill.

An adequate number and ample range of graded, stepwise, supervised community housing settings must be established.—While many of the homeless may benefit from temporary housing such as shelters (a site which is being emphasized, perhaps to the detriment of others, as Federal, State, and local governments grapple with the plight of the homeless as winter approaches), and while some small portion of the severely chronically mentally ill are able to graduate to independent living, for the vast majority, neither shelters nor mainstream low-cost housing (such as section 8 or section 202 housing) are appropriate. Most housing settings that require people to manage by themselves are beyond the capabilities of the chronically mentally ill. We need only look to the sorry experience of the mentally ill now housed in many SRO's to see just one example. Instead, there must be settings offering different

levels of supervision, both more and less intensive, including quarterway and halfway houses, lodges and camps, board and care homes, satellite housing, foster or family care, and crisis or temporary hotels. Organized living arrangements can help stabilize the lives of such individuals to a marked extent. The supervision provided could help ensure that medications are taken, that an address is available for the delivery of SSI, SSDI, Medicare and Medicaid payments, that there is an address available for case workers and health and supportive care providers.

Adequate, comprehensive, and accessible psychiatric and rehabilitative services must be available and must be assertively provided through outreach services when necessary.—First, there must be an adequate number of direct psychiatric services, both on the streets and in the housing provided, when appropriate, that provide (a) outreach contact with the mentally ill in the community, (b) psychiatric assessment and evaluation, (c) crisis intervention, including hospitalization, (d) individualized treatment plans, (e) psychotropic medication and other somatic therapies, and (f) psychosocial treatment. A clear model for this sort of service system was established in the 1980 Mental Health Systems Act, Public Law 98-398, though regrettably, that law was repealed. The Older Americans Act as amended, does contain the model developed for such outreach services for the mentally ill elderly under the MHSA, though the demonstrations provided under the OAA have been extremely limited.

Second, there must be an adequate number of rehabilitative services, providing socialization experiences, training in the skills of everyday living, and social rehabilitation. Programs providing such services could be patterned after day treatment programs, or some of the more social support related services provided by senior centers. Third, both treatment and rehabilitative services must be provided assertively—for instance, by going out to patients' living settings if they do not or cannot come to a centralized program. (This is not dissimilar to some of the homemakers-chore and other home-based health and rehabilitative services provided under programs for the aged, though it is absolutely critical not to underestimate the difficulty of working with many of these patients.)

General medical assessment and care must be available.—Since we know that the chronically mentally ill have three times the morbidity and mortality of their counterparts of the same age in the general population, and the homeless even higher rates, the ready availability of general medical care is essential and critical. Again, this could occur within the housing sites, within the rehabilitation programs. It is important to remember that existing medical service reimbursement, through Medicare and Medicaid, could become far more readily available to such individuals once a fixed address and appropriate case management of such persons is in place. Moreover, outpatient treatment, whether in centers such as CMHC's or community health centers, is far less expensive to all levels of payor (Federal, State, and local public sector as well as private payors) than is the traditional mode of care sought by the homeless mentally ill—the emergency room, often as the result of intervention by corrections officials.

Crisis services must be available and accessible to both the chronically mentally ill homeless and the chronically mentally ill in general.—Too often, the homeless mentally ill who are in crisis are ignored because they are presumed, as part of the larger homeless population, to reject all conventional forms of help. Even more inappropriately, they may be put into inpatient hospital units when rapid, specific interventions such as medication or crisis housing would be effective and less costly. Others may be incarcerated in corrections facilities, even more inappropriate than other settings. Others, in need of acute hospitalization are denied it because of restrictive admission criteria or commitment laws. In any case, it will be difficult to provide adequate crisis services to the homeless mentally ill until they are conceptualized and treated separately from the large numbers of other homeless persons.

A system of responsibility for the chronically mentally ill living in the community must be established, with the goal of ensuring that ultimately each patient has one person responsible for his or her care.—Clearly, the shift of psychiatric care from institutional to community settings does not in any way eliminate the need to continue the provision of comprehensive services to the mentally ill. Indeed, the need for asylum for such persons may be even greater when confronted by the larger community setting. As a result, society must declare a public policy of responsibility for the mentally ill who are unable to meet their own needs; governments must designate programs in each region or locality as core agencies responsible and accountable for the care of the chronically mentally ill living there; and the staff of these agencies must be assigned individual patients for whom they are responsible. The ultimate goal must be to ensure that each chronically mentally ill person in this

country has one person—a case member, if you will—who is responsible for his or her treatment and care.

For the more than 50 percent of the chronically ill population living at home or those with positive ongoing relationships with their families, programs such as respite care must be provided to enhance the family's ability to provide a support system. Where the use of family systems is not feasible, the patient must be linked up with a formal community support system.

In any case, the entire burden must not be allowed to fall upon families as if this illness—as compared to a physical illness—were their fault and they should be punished.

There are numerous models upon which such a system can be based, the most well defined and recent is that set forth in the Mental Health Systems Act, providing for both services and case management of the population of chronically mentally ill, aged and child mentally ill in particular. Respite care has its precedence in programs serving the elderly and the terminally ill, as does the integration of family, when available, into the service delivery network. Moreover, these services can draw upon existing individual and categorical financial mechanisms—Medicare, Medicaid, SSI, SSDI, title XX funding, etc.

Basic changes must be made in legal and administrative procedures to ensure continuing community care for the chronically mentally ill.—In the 1960's and 1970's more stringent commitment laws and patients' rights advocacy remedied some egregious abuses in public hospital care, but at the same time these changes neglected patient's rights to high quality comprehensive outpatient care as well as the rights of families and society. New laws and procedures must be developed to ensure provision of psychiatric care in the community—that is to guarantee a right to treatment regardless of the setting.

Further, it must become easier to obtain conservatorship status for outpatients who are so gravely disabled and/or have such impaired judgment that they cannot care for themselves in the community without legally sanctioned supervision. Involuntary commitment laws must be made more humane to permit prompt return to active inpatient treatment for patients when acute exacerbations of their illnesses make their lives in the community chaotic and unbearable. Involuntary treatment laws should be revised to allow the option of outpatient civil commitment; in states that already have provisions for such treatment, that mechanism should be more widely used. Finally, advocacy efforts should be focused on the availability of competent care in the community.

Essentially, it is critical to respond both to patients' rights and medical needs, insofar as both inpatient and community based treatment and services are concerned. Congress recognized this need in this statement of findings in Public Law 98-621 (which provided for the transfer of the St. Elizabeth's Hospital to the government of the District of Columbia). The law recognized that new systems of care must be responsive to and protect not only "patients' rights" but also patients' "medical needs". Moreover, advocates and States can no longer afford simply to close facilities and deinstitutionalize the population. They must first ensure that the requisite constellation of service and treatment needs is met, as described in the Medical Health Systems Act. We must ensure not only that those now on the streets become part of this more humane system, but also that those now in facilities or in need of community-based care do not become the homeless for lack of managed, available care and treatment.

One facet of the availability of continuing community care for the chronically mentally ill is the availability of federally-supported health insurance coverage for such individuals. Without insurance, whether Medicare or Medicaid, outpatient treatment becomes virtually unobtainable. There are few dollars which would have been utilized at the State facility which follow the patient. Medicare and Medicaid (in most States) have severely curtailed benefits for the treatment of mental illness, in far lesser amounts than needed by the chronically mentally ill. Their pharmaceutical needs—psychoactive medication in most cases—is expensive and uncovered. Broadened Medicare and Medicaid coverage, as envisioned in legislation you introduced, Mr. Chairman (S. 1289 in the 96th Congress), is warranted for all, but certainly for those chronically mentally ill identified in this testimony.

Ongoing asylum and sanctuary should be available for that small proportion of the chronically mentally ill who do not respond to current methods of treatment and rehabilitation.—Some patients, even with high-quality treatment and rehabilitation efforts, remain dangerous or gravely disabled. For these patients, there is pressing need for ongoing, caring, quality asylum in long-term settings, whether in hospitals or in facilities such as California's locked skilled nursing facilities with special pro-

grams for the mentally ill. Again, changes in commitment procedures and laws regarding SNF and ICF coverage for the mentally ill would be required.

A system of coordination among funding sources and implementation agencies must be established.—The ultimate objective must be a true system of care rather than a loose network or confederation of services, and an ease of communication among different types of agencies (for example, psychiatric, social, vocational and housing) as well as up and down governmental ladder from local through Federal. We have heard all too often about isolated programs to serve the homeless mentally ill, which are barely surviving financially due to internacine warfare among public and private funding sources over who will *not* pay for the programs. How one can mandate such cooperation and coordination across levels of government and across agencies (since all too often, administrative costs associated with such coordination themselves drain much of the funding resource available for actual program development) is a matter of legislative legerdemain. It will take your creative legislative abilities to be certain that it happens, if the nationwide problem confronting us all is to be resolved.

General social services must be provided.—Such services include escort services to agencies and potential residential placements, help with application to entitlement programs, and assistance in mobilizing the resources of the family. It is possible that the case manager identified earlier could help perform many of these functions, particularly those involving access to the various segments of the service delivery system.

An adequate number of professionals and paraprofessionals must be trained for community care of the chronically mentally ill.—While the NIMH clinical training program has fallen into disrepute within the context of this administration's proposed budgeting, it could, with adequate resources and congressional direction, develop the manpower necessary to meet the community care needs of the chronically mentally ill. Perhaps volunteer agencies such as VISTA and others, could also be trained to perform some of the outreach and case management functions which do not require trained medical professionals.

Research into the causes and treatment of both chronic mental illness and homelessness needs to be expanded.—While our knowledge has greatly advanced in recent years, it is still limited. Our understanding of, for example, differential therapeutics—that is, what treatment works for which patients in what settings—is in its infancy and requires increased resources and attention. The ADAMHA research programs have made some efforts in these directions, but clearly need greater financial resource commitment to do more, just as greater resources are needed for brain research into the causes of mental illness.

More accurate epidemiological data need to be gathered and analyzed.

Finally, additional monies must be expended for longer-term solutions for the homeless mentally ill.—Each of the recommendations cited above will engender some expenditure of funds—whether Federal, State, or local. The problem exists at each of these levels—inadequate Federal health insurance funding for the treatment of the homeless mentally ill, inadequate State and local followup of those deinstitutionalized to ensure placement due to lack of personnel, insufficient housing to meet the shelter needs of these persons, insufficient effort at each level to identify the benefits to which such persons may be entitled and to seek means of ensuring they can receive such benefits.

Clearly, to solve the problems of the homeless in general and the homeless mentally ill in particular will require a great deal of resource commitment. Perhaps some can be generated through the private sector, but in the main, we suspect it will have to come from government entities. Based on what we have seen to date, the homeless mentally ill are trapped in a cross-fire of allegations from one level of government to another as to whose responsibility the homeless are; they are trapped in the cross-fire of those advocating deinstitutionalization on the one hand, and those urging greater attention to medical needs on the other (ironically, not necessarily opposing points of view). Without direction from the Federal Government, without impetus for changes in housing, health care (including insurance coverage), rehabilitation, and social support networks, the mentally ill homeless will remain the untouchables unable to live outside our society because there are no services, and unhelped within our society because of fear, misunderstanding, and lack of commitment.

The American Psychiatric Association would like to work with you, Mr. Chairman, and your committee, to help craft a meaningful, long-term solution to the problems confronted by the mentally ill homeless and other homeless persons across our Nation. We have seen our joint efforts come to fruition in the past—in the passage after almost 3 years of omnibus Social Security disability insurance legisla-

tion—and know that our mutual commitment to meeting the needs of yet another population too ill, too disenfranchised, too voiceless to help itself, will not fail.

Chairman HEINZ. Our next witness is Dr. Harvey Vieth of the Department of Health and Human Services. He has a background as a distinguished public servant in El Paso County, CO. El Paso County is in Colorado, and why it is not in Texas, I do not know. It surrounds Colorado Springs, the county seat.

Dr. Vieth reminded me earlier that Colorado is the home of Colorado College. For somebody who went to Yale and Harvard, Harvey, you are in deep trouble.

Dr. VIETH. I still come from Colorado so I am all right.

Chairman HEINZ. Please proceed.

STATEMENT OF DR. HARVEY R. VIETH, WASHINGTON, DC, CHAIRMAN, FEDERAL TASK FORCE ON FOOD AND SHELTER FOR THE HOMELESS

Dr. VIETH. Thank you very much. I appreciate the introduction and I am very glad to be here to testify in front of you, Senator.

I have a prepared statement which I will summarize, but I would like to go into this in some detail because many are not familiar with the task force.

Although the Department of Health and Human Services has long been charged with the responsibility for administering programs for the elderly and disabled Americans, it has only been under the leadership of Secretary Heckler that we have sharpened the focus on the problems of homeless Americans, not just the elderly, but overall.

The task force, unique as the first interagency unit dealing with the homeless to be established by a departmental initiative rather than by statute, is chaired by HHS and includes representatives from 12 major agencies: Agriculture, Defense, Interior, Labor, Housing and Urban Development, Transportation, General Services Administration, Federal Emergency Management Administration, ACTION, the Census Bureau, the Veterans' Administration, and the Postal Service.

Before discussing the Federal involvement and the activities of the task force, I would like to briefly describe the overall effort to help the homeless, lest the Federal role appear to be more preponderant than it really is or should be.

The vast majority of projects to assist the homeless are being undertaken by the private sector, including businesses, local nonprofit groups, churches and synagogues, and other voluntary organizations. For example, 54 percent of shelters are operated by nonreligious private groups, 40 percent by religious groups, and 6 percent by city and county governments. Local governments also play a major role in the provision of food, shelter, and other services for the homeless.

According to the Department of Housing and Urban Development report on the homeless, 80 percent of local governments, cities, and counties do at least provide one of the following: operate shelters; give money to private groups to operate shelters or other services; lease or rehabilitate buildings for private shelter provid-

ers; furnish vouchers to homeless people to use in hotels, motels, or apartments.

States have provided services in large part by passing through to local governments moneys from Federal sources such as FEMA, the Community Services and Social Services Block Grants, Community Development Block Grants, and recently a few States have appropriated substantial sums to provide either social services or shelter for the homeless. New York has committed $21 million for construction during 1985. In addition, a commission appointed by Governor Cuomo has just recommended allocating $330 million in additional State funds over the next 5 to 8 years for community-based services for the mentally ill. The commission also urged establishment of a system of financing to assure that mental health funds follow the patient from the institutions, with each local agency being held accountable for care in its area.

The role of the Federal task force which I chair can be summed up as follows. First of all, we try to identify potential resources controlled by Federal agencies. We cut through redtape and help remove impediments so that these resources can be more effectively targeted to the homeless, and act in general as a facilitator or a broker between local governments, shelter providers on the one hand, and Federal agencies on the other, serving as an information source on the homeless issues for the White House, Congress, and the providers in the community. The task force also identifies examples of successful local approaches to the problem of homelessness and assists in disseminating this information throughout the provider community.

Each of the agencies on the task force controls resources that can be of some benefit to the homeless. I will describe briefly some of those resources at HHS.

I am just going to list them, and have more complete information for anybody who wants it.

There is a $23 million Runaway and Homeless Youth Program which provides overnight shelter, day centers, and also a hotline for children in trouble.

The Office of Community Services, of which I am the Director in addition to my duties as the chairman of the task force, has community service block grant funds, of which approximately one-fifth or $60 million provides some form of emergency food, shelter, clothing, medical or related services for the needy, including the homeless.

At the Alcohol, Drug Abuse, and Mental Health Administration, $227 million was awarded to the States in the form of block grants.

In 1983, the National Institute of Mental Health made grant awards to four States to simulate studies of the demographics and characteristics of the homeless mentally ill. I will not go through all of those. Some of them are listed in this report.

The Office of Human Development Services has a full range of projects focusing on the elderly and others on new ways of coordinating and integrating the resources of the public and private sector. Some of these directly relate to the homeless.

I would like now to return—I will not go through all of this because we do have a time problem—to the role of the task force. Not only have we laid solid groundwork over the last year—the task

force was formed October 1, 1983—we have also accomplished much. A great deal still remains to be done to target existing Federal resources more directly to the homeless.

The task force will be focusing on the following priorities in the upcoming months. We will continue to identify existing resources that can be used to help the homeless and to produce interagency agreements to make these resources available to organizations serving the homeless. For those of you who have not dealt with the Federal bureaucracy in Washington, it takes a lot of effort and negotiation to put together interagency agreements.

We do have an agreement between the Department of Defense and HHS in which we are making available nonmarketable food to food banks from military commissaries, and this program is becoming more and more successful and will help feed the homeless. The task force has negotiated eight agreements and we continue to work on others. We are also working on relationships with national organizations such as the National Citizens Committee for Food and Shelter, the National Mental Health Association, the American Psychiatric Association, the American Institute of Architects, and veterans' organizations. These organizations can be of great assistance in mobilizing private sector support throughout the Nation.

I go all around the Nation, and I have been in many shelters. Most of the time I end up eating in soup kitchens. I see there is the possibility of creative thinking that can come about by putting together a coalition of people who ordinarily would not get together. They can focus strictly on the homeless and, of course, that would include a lot of the mental health problems in which you are interested.

The task force responds to State and local requests for help by cutting redtape and by furnishing guidance on resources available through HHS' Regional Directors and through other regional and national networks. We work with the private sector to insure that information on resources, methods, and potential problems is available to those who want to set up food banks and shelters.

For example, the task force had 30 providers come to Washington last March. We put together a resource guide on food and shelter—setting up soup kitchens, setting up shelters—which includes long-term care such as the work of the St. Francis Fathers in New York who are helping 114 schizophrenics. We are trying to step beyond just shelter. In other words, we feel shelter is the beginning, not the end, as some do.

We want to continue our work in concert with other agencies to organize conferences and workshops. We want to get together with you and get your ideas. We also want to work with the Social Security Administration, the States and localities, and the shelter operations to continue our work to identify those shelter residents who qualify under existing law for Social Security disability or Supplemental Security Income Program benefits.

Senator, you might be especially interested to know that SSA, a member of the task force, is also moving to eliminate barriers to providing help for the homeless. SSA believes there are three primary reasons why homeless people and SSA have problems in establishing the benefits that homeless should have benefits to.

One, homeless people are difficult to locate and contact.

Two, they have limited exposure to traditional news sources of information about the benefit programs that are available.

Three, they do not know how to, or are reluctant to, file, pursue, or appeal a claim for benefits.

SSA recognizes its obligation to address the special problems of the homeless. SSA's initiatives are designed to establish and maintain a connection with its benefit programs for those who are eligible. It is working with shelters, soup kitchens, churches, and other organizations to locate homeless people who may qualify for Social Security and SSI benefits. SSA workers are sent to shelters, soup kitchens, and other locations to take applications from the homeless and to follow up on claims as necessary. SSA workers ask the people who administer these facilities to keep track of applicants so that any additional evidence needed to establish entitlement can be obtained. This special assistance and coordination with facility administrators is especially important in getting the medical evidence necessary in claims for disability benefits.

SSA has established an operational plan for serving the homeless under which SSA's 10 regional offices and its more than 1,300 field offices are required to carry out specific initiatives to assure that the homeless receive information about the Supplemental Security Income or Social Security Programs and any benefit to which they are entitled.

The regional plans are serving to heighten the importance of local level coordination efforts and to bring uniformity to SSA's efforts. Progress on the SSI front has been heartening.

As the task force moves into its second year, we will continue our efforts in this area, as well as in other program areas pertinent to the problems of the homeless. I would caution the committee that the Federal Government cannot do the job alone. The continued cooperation of State and local governments and the private sector is absolutely critical to insure the wisest use of all existing resources.

I shall be happy to answer any questions.

Chairman HEINZ. Dr. Vieth, thank you very much. I will have some questions for you.

At this point we will put into the record your entire statement.

[The prepared statement of Dr. Vieth follows:]

PREPARED STATEMENT OF DR. HARVEY R. VIETH

Mr. Chairman and members of the committee, my name is Harvey R. Vieth and I am the Chairman of the Federal Task Force on Food and Shelter for the Homeless. I am pleased to appear before you today to discuss the nature and extent of Federal involvement in efforts to help homeless persons and especially those among the homeless who are either elderly or chronically mentally ill. Although the Department of Health and Human Services (HHS) has long been charged with the responsibility for administering programs for elderly and disabled Americans, it has only been under the leadership of Secretary Margaret M. Heckler that we have sharpened the focus on the problems of homeless Americans.

The Secretary's deep personal concern over the plight of the homeless was reflected in her decision 1 year ago to create the Tasks Force on the Homeless "to serve," in her words, "as a catalyst so that the compassionate work which has long been carried on by public and private groups is augmented, supplemented and strengthened." The Task Force, unique as the first interagency unit dealing with the homeless to be established by a departmental initiative rather than by statute, is chaired by HHS and includes representatives from 12 other Federal agencies: the Depart-

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ments of Agriculture, Defense, Interior, Labor, Housing and Urban Development, and Transportation, as well as the General Services Administration, the Federal Emergency Management Agency, ACTION, the Census Bureau, the Veterans Administration, and the Postal Service.

Before discussing the Federal involvement and the activities of the Task Force, I would like to briefly describe the overall effort to help the homeless, lest the Federal role appear to be more preponderant than it really is or should be.

The vast majority of projects to assist the homeless are being undertaken by the private sector, including businesses, local nonprofit groups, churches and synagogues, and other voluntary organizations. For example, 54 percent of shelters are operated by nonreligious private groups, 40 percent by religious groups, and 6 percent by city and county governments. A variety of private sources provided 63 percent (or $138 million) of the 1983 operating expenses for all shelters. In addition, an average of four volunteer staff hours per bed per night was donated to shelters.[1]

In the area of food assistance, in 1983, of the 300-odd food banks in the United States, the 79 which belong to the second Harvest network distributed to organizations serving the poor some 118 million pounds of food donated by the food industry and other private givers. The dollar value of this food was estimated to be $197 million. Forty percent of this amount (or $78 million worth of food) went to soup kitchens and congregate feeding sites patronized by many homeless persons. In addition, under an agreement negotiated by the Task Force, some 20 food banks received around 500,000 pounds of surplus food from vendors serving military commissaries.[2]

Local governments also play a major role in the provision of food, shelter and other services for the homeless. According to the HUD report, about 80 percent of local governments (cities and counties) do at least one of the following: operate shelters; give money to private groups to operate shelter or other services; lease or rehabilitate buildings for private shelter providers; and furnish vouchers to homeless persons for use in hotels, motels, and apartments.[3]

States have provided services mostly by "passing through" to local governments moneys from Federal sources such as the Federal Emergency Management Agency, HHS (through the community services and social services block grants), and HUD (through the community development block grant). Recently, a few States (Maryland, New Jersey, California, Massachusetts and New York) appropriated substantial sums to provide either social services or shelter for the homeless. For example, New York has committed $21 million for construction during fiscal year 1985. In addition, a commission appointed by Governor Cuomo has just recommended allocating $330 million in additional State funds over the next 5 to 8 years for community-based services for the mentally ill. The commission also urged establishment of a system of financing to assure that mental health funds "follow the patient" from the institutions, with each local agency being held accountable for care in its area. Due to the economic upturn, the majority of States are registering a sizable surplus in State revenues, making it possible for more State funds to be available in the future to help the homeless.

THE FEDERAL TASK FORCE ON FOOD AND SHELTER FOR THE HOMELESS

The original charter of the Task Force was based on the following assumptions:

(1) *Homelessness is essentially a local problem.*—The problem originates at the community level and the focus of efforts to resolve it must be at this same level. The needs of the homeless are best assessed at the local level, and it is only there that the appropriate support and assistance can be pulled together and delivered creatively and with caring. More and more communities are beginning to realize this and are taking the lead by organizing partnerships between businesses, churches, private individuals, care providers, and State and local service agencies to establish shelter and rehabilitation facilities for the homeless.

(2) *The Federal Government already has programs and resources to help the homeless.*—There is a considerable array of existing resources at the Federal level which have not yet been fully utilized. These resources include benefit programs for which the homeless are eligible and surplus building space, supplies, equipment and foodstuffs, etc. There are also more resources at the State and

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[1] The statistics in the above paragraph are from "A Report to the Secretary on the Homeless and Emergency Shelters," issued by the U.S. Department of Housing and Urban Development.

[2] The statistics in the above paragraphs are from "A Report to the Secretary on the Homeless and Emergency Shelters," issued by the U.S. Department of Housing and Urban Development.

[3] Ibid.

local level which can be applied to the problems of the homeless, thanks to budget surpluses generated by the economic upturn.

(3) *Knowledge of strategies used in many communities to help the homeless needs to be transferred to other communities.*—The various kinds of things that need to be done to meet the needs of the different categories of homeless persons are all being done now somewhere in the country; what is needed is a systematic effort to document and disseminate what is happening, so that other communites can benefit from this knowledge.

In the light of these assumptions, the role of the Task Force can be summed up as follows:

(1) Identifying potential resources controlled by Federal agencies.

(2) Cutting redtape and helping to remove impediments so that these resources can be more effectively targeted to the homeless.

(3) Acting in general as a facilitator or broker between local governments and shelter providers on the one hand and Federal agencies on the other, but only when such assistance is requested by a local group and/or local officials.

(4) Serving as an information source on homeless issues for the White House, Congress, and the provider community.

(5) Assisting in identifying examples of successful local approaches to the problem of homelessness and assisting in the dissemination of this information throughout the provider community.

Each of the agencies sitting on the Task Force controls resources that can be of some benefit to the homeless: I propose to describe briefly the resources and programs of the lead agency of the Task Force, HHS.

THE RUNAWAY AND HOMELESS YOUTH PROGRAM

The Runaway and Homeless Youth Program provided, in fiscal year 1984, over $23 million for (a) overnight shelters which served 60,400 children, (b) day centers which offered counseling and other supportive services to some 181,200 young people, and (3) a nationwide hotline which served 250,000 children.

THE COMMUNITY SERVICES BLOCK GRANT PROGRAM (CSBG)

The CSBG Program provides funds to the States for antipoverty efforts (e.g., services to secure employment and to gain adequate housing, emergency assistance, health and nutrition). In fiscal year 1982, more than one-fifth—or roughly $60 million—of CSBG funds were used by the States to provide some form of emergency food, shelter, clothing, medical and related services to the needy, including the homeless. Figures on the number of homeless served are not available. The emergency services were administered by a network of 900-odd community action agencies which receive the bulk of CSBG funds. While no figures are available for subsequent years, it is probable that the level of emergency food and shelter services still represents around one-fifth of the CSBG total.

THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH (ADAMHA) BLOCK GRANTS

In fiscal year 1984, $227.5 million was awarded to the States in the form of ADAMHA block grants for mental health purposes. The States were encouraged to give priority to the problems of the mentally ill.

In a 1983 report to Congress it was noted that "almost without exception, the number one service priority of the State mental health commissioners appears to have been service to the chronically mentally ill * * *" whether to hospitals, communities or those in danger of rehospitalization. The report added that "the elderly who are also chronically mentally ill probably fare better with respect to receiving mental health services."

Congress also showed its awareness of the need for States to address the rehabilitative components of mental illness in a Senate committee report on the fiscal year 1985 ADAMHA block grant authorization. According to the report:

"The community mental health care systems should give priority to preparing chronically mentally ill persons for community living. Programs must therefore become increasingly rehabilitative in emphasis. The goal is simply to achieve as much independence in living in the community as possible and to reduce the painful and costly rotation of mentally ill persons in and out of the hospitals."

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

In 1983, NIMH made grant awards to four States (Massachusetts, California, Michigan, and Wisconsin) to stimulate studies of the demographics and characteris-

tics of the homeless mentally ill. The total of the four awards was $364,000. In addition, two research grants were made—one to Ohio and one to New York—totaling $225,000 and focusing on the chronically mentally ill homeless. In April 1984, the researchers for the above grants were convened to compare results and determine what had been learned about the mentally ill and what further research was needed. NIMH also commissioned an analytic review of the literature examining the relationship between homelessness and mental illness.

Other NIMH initiatives included an Administrator's roundtable which brought together a group of providers to discuss the alcohol, drug abuse, and mental health problems of the homeless; a grant to the State of Michigan, which contracted with the American Psychiatric Association to describe model mental health programs serving the homeless mentally ill; and support for a meeting of 15 national mental health organizations in Washington convened by the American Public Health Association to share information on current concerns and activities and to discuss future public policy concerning the homeless mentally ill. In 1985, NIMH plans to convene a meeting of providers to examine approaches to working with this difficult and hard-to-reach population. In addition, four grants to States are planned to support innovative demonstration projects serving the homeless mentally ill.

Finally, as part of a broader Secretarial initiative focused on homelessness, NIMH provides technical assistance to States, localities and private organizations interested in this very vulnerable and disabled population.

OFFICE OF HUMAN DEVELOPMENT SERVICES (HDS)

HDS has funded a range of projects, some focusing on the elderly and others, on new ways of coordinating and integrating the resources of the public and private sector.

Awards relating to the elderly included a grant to the Massachusetts Department of Elder Affairs to evaluate State, Federal, and private congregate housing programs in the State of Massachusetts. The goals of this project are to: (1) Determine if congregate housing in Massachusetts has reduced the risk of premature institutionalization of the elderly; (2) provide a basis for decisionmaking regarding the most efficient and effective management of congregate housing; and (3) produce a handbook describing the effects of physical design, support systems and management policies on the quality of life of elderly residents in congregate facilities.

A second award relating in part to the elderly was made to the New York State Human Resources Administration to conduct research on effective strategies for serving specified homeless subpopulations. These strategies will then be implemented in New York City through demonstration projects specifically designed to reach the elderly, youth, employables, and chronically mentally ill.

HDS has funded three projects testing better ways of coordinating resources. The first award was to the Permanent Charity Fund of Boston to establish a model for the creation of public/private partnerships which address persistent and pervasive human service needs. This model may be replicated by other community foundations and directed at the needs of the homeless, the hungry, the elderly, and other populations in need. The goal of the Fund for the Homeless is to raise $1 million which will be used to set up 10 new shelters for the homeless in the State of Massachusetts.

A second award was to the Massachusetts Association for Mental Health, Inc., to develop a model of service delivery for the homeless which targets available resources and uses case management techniques. It will also facilitate the dissemination of this model in the State of Massachusetts through workshops and publications. The use of case management techniques will enable public and private agencies to provide only those services which are needed, to coordinate service delivery, and to work toward stable living arrangements. This will eliminate duplication of services and reduce the number of homeless persons who are totally dependent on public sector programs.

The third award was to the New York City Partnership to improve the quality and efficiency of emergency shelter services delivered by the New York City Human Resources Administration by applying business management techniques to their delivery. The project will develop performance indicators and trends, apply private-sector management and contracting practices to improve program effectiveness and reduce costs, examine the feasibility of a voucher system, and help coordinate the shelter program with existing social services.

It should be noted that there is an office in HDS which is devoted exclusively to the problems of the elderly: the Administration on Aging (AoA). Under title III of the Older Americans Act, AoA awarded grants totaling $520 million for various

types of nutrition programs for the elderly, and $265 million for other types of supportive services. These moneys are distributed by formula to the States which then reallocate it to over 660 area agencies on aging (AAA's) who, in turn, pass most of it on to private sector providers of services. Priorities among supportive services include access (transportation, outreach, information referral), in-home services (home help, telephones, yard maintenance, etc.) and legal services. Other options for use of grant funds include: health care, education, training, recreation, counseling, housing repair and renovation, access to housing, avoiding institutionalization, health screening, crime prevention, and victim assistance.

There is obviously an important potential in AoA programs for serving the elderly homeless but there are no figures available on the number of homeless among AoA's clients.

Returning to the role of the Federal Task Force, while solid groundwork has been laid and much has been accomplished, a great deal remains to be done to target existing Federal resources more directly toward the homeless. The Task Force will be focusing on the following priorities in the coming months:

(1) Continue to identify existing resources that can be used to help the homeless and produce interagency agreements to make these resources available to organizations serving the homeless. The Task Force will also review existing interagency agreements and revise them where necessary.

(2) Continue our working relationships with national organizations such as The National Citizens Committee for Food and Shelter, the National Mental Health Association, the American Psychiatric Association, the American Institute of Architects, veterans' organizations, etc. These organizations can be of great assistance in mobilizing private sector support throughout the Nation.

(3) Respond to state and local requests for help by cutting redtape and by furnishing guidance on resources available through HHS' regional directors and through other regional and national networks. By acting as a broker between local providers and Federal agencies, the Task Force can speed up the application process and, where appropriate, obtain a waiver of restrictive practices.

(4) Work with the private sector to ensure that information on resources, methods, and potential problems (and how to deal with them) are available to those who want to set up food banks or shelters.

(5) In concert with other agencies, organize conferences, workshops and regional meetings for shelter operators, service providers and State and local officials, with a view to producing more "how-to-do-it" guides for local use.

(6) Work with the Social Security Administration (SSA), the States and localities, and shelter operators to identify those shelter residents who qualify under existing law for Social Security disability or supplemental income benefits. These residents could then provide for their own housing, which could in turn qualify them for other existing programs that require recipients to have a fixed address.

EFFORTS TO REMOVE BARRIERS

The efforts made during the past year by HUD, DOD, GSA, FmHA, and DOE to alter customary procedures and waive restrictive practices so as to make available to the homeless surplus buildings, food and equipment, all testify to the Task Force's success in removing barriers.

SSA, a member of the Task Force, has also been moving to eliminate barriers to providing help to the homeless. SSA believes there are three primary reasons why homeless people, and SSA, have problems in establishing the entitlement of the homeless to benefits:

(1) Homeless people are difficult to locate and contact.

(2) They have limited exposure to traditional news sources of information about the benefit programs that are available; and

(3) They don't know how, or are reluctant, to file, pursue, or appeal a claim for benefits.

SSA recognizes its obligation to address the special problems of the homeless. SSA's initiatives are designed to establish and maintain a connection with its benefit programs for those who are eligible. It is working with shelters, soup kitchens, churches, and other organizations to locate homeless people who may qualify for Social Security and SSI benefits. SSA workers are sent to shelters, soup kitchens, and other locations to take applications from the homeless and to follow up on claims as necessary. SSA workers ask the people who administer these facilities to help keep track of the applicants so that any additional evidence needed to establish entitlement can be obtained. This special assistance and coordination with facility

administrators is especially important in getting the medical evidence necessary in claims for disability benefits.

When a homeless person's entitlement for benefits has been established, SSA can make special arrangements for delivery benefits and notices. Benefits can be deposited directly into a bank account. They can be sent to a shelter or interested third party, or they can be delivered to a post office for general delivery or to a Social Security office for pickup. When an eligible homeless person is unable to handle his finances, a benefit can be paid on his behalf to a relative, friend, shelter, or organization.

Homeless people may rely on charitable assistance to help meet their needs for food, clothing, and shelter. In determining individuals' eligibility and benefit amounts, the SSI program excludes such assistance from income when provided in kind by private nonprofit organizations. In addition, under an exception to the general prohibition of SSI eligibility for residents of public institutions, residents of public emergency shelters for the homeless may be eligible for up to 3 months in any 12-month period. This exception was added by legislation enacted in 1983 and is intended to provide income so individuals will be able to move to more permanent living arrangements.

SSA has established an operational plan for serving the homeless under which SSA's 10 regional offices and its more than 1,300 field offices are required to carry out specific initiatives to assure that the homeless receive information about the supplemental security income or Social Security programs and any benefit to which they are entitled.

Under this plan, regional offices will:

—Designate one field office manager to act as the key contact in large metropolitan centers for community groups which are coordinating services to the homeless.

—Compile regional directories of services available to the homeless and distribute these to SSA field offices, SSA teleservice centers, and to other agencies involved with assistance to the homeless.

—Designate a regional office contact person for homeless initiatives to be available to other agencies as consultant, to share new ideas or approaches for reaching the homeless, and to coordinate SSA field office activities in this area.

SSA field offices will:

—Maintain current information about providers of services to the homeless.

—Establish and maintain liaison between the SSA office and the providers of services to ensure that program information is available to the provider's staff, to acquaint the provider's staff with SSA operational procedures, and to request the provider's assistance in identifying homeless persons who may be eligible for benefits.

—Establish a parallel liaison with the local mayor's office (or other appropriate level of government).

The regional plans are serving to heighten the importance of local level coordination efforts and to bring uniformity to SSA's efforts.

Progress on the SSI front has been heartening and as the Task Force moves into its second year, we will continue our efforts in this area, as well as in other program areas pertinent to the problems of the homeless. But I would caution the committee that the Federal Government can't do the job alone. The continued cooperation of State and local governments and the private sector is absolutely critical to ensure the wisest use of all existing resources.

I shall be happy now to answer any questions the committee may have. Thank you.

Chairman HEINZ. Mr. Brooks.

STATEMENT OF LEO A. BROOKS, MANAGING DIRECTOR, CITY OF PHILADELPHIA, PA

Mr. BROOKS. Mr. Chairman, first let me thank you for the concern that brings you to Philadelphia to observe firsthand the devastating effects of this most vexing social problem and see what we are doing to cope with it here.

Before I tell you about our efforts, let me outline the scope of the Philadelphia problem.

On any given day, there are between 2,000 and 3,000 homeless persons on the streets of Philadelphia. Our contact with them over the last several years indicates that some will find shelter even as others lose theirs, so in the course of a year we are talking about at least 7,000 people who spend a month or more in the streets.

Of these, about 25 percent are chronically mentally ill. Fifteen percent are acute or chronic substance abusers, primarily alcohol. About 23 percent are homeless family members who present themselves for help in groups of two or more, and about 45 percent are economically deprived. You will note that these percentages do not add exactly up to 100 because some individuals are found in more than one category.

This decription of the affected population provides the most important basic insight about homelessness, namely that homelessness is not their primary problem. Rather, their primary problems are typically a combination of mental illness, addiction, or insufficient income.

The implication of this is that emergency shelters are not a straightforward response to some clearly defined problem called homelessness. No, they are last resort institutions that deal with a variety of independent problems with which society as a whole has failed to come to grips.

Now we are in a position to understand how cities like Philadelphia have in recent years borne the brunt of State and Federal decisions which have swollen this catchall last resort category called homelessness.

In the 1960's and 1970's, States economized by discharging hundreds and thousands from mental hospitals, but the State and Federal Governments never provided the promised range of supportive housing options which could have offered these mentally ill a decent life in our local communities.

In the midst of the 1981–83 recession, Pennsylvania Act 75 drastically curtailed eligibility for general assistance cash, and 30,000 people in Philadelphia alone were left with no source of income. At the same time, eligibility for supplemental security income and disability benefits were throttled back by regulatory mandate in Washington.

Today, at a time when epidemic drug and alcohol abuse show no signs of abating, funds for substance abuse treatment and rehabilitation are being cut across the board.

In the area of housing, most directly related to homelessness, Philadelphia Federal grants totaled $10 million less in fiscal 1985 than they did in 1981. This is in the face of inevitable long-term decay in our low-income housing stock, most of which is now 50 to 100 years old.

Even the funds reaching Philadelphia from Federal emergency agencies, specifically to address this problem, have declined from $1,600,000 just a year ago to only $600,000 this year.

These and similar trends we could cite add up to a quite deliberate and long-term shifting of the burden of care for society's most vulnerable members to the shoulders of local government.

Since the poor and the vulnerable have always gravitated toward cities and thereby comprise a disproportionate share of the popula-

tion, this withdrawal of State and Federal responsibility is inequitable and regressive from a policy point of view.

I could cite a wealth of statistics, Mr. Chairman, to show the impact of these trends in Philadelphia, but I will just use two. The number of nights in shelters provided by Philadelphia's Department of Human Services, went from 221,000 in 1982 to 283,000 in 1983, and over 410,000 in 1984, for an 86-percent increase in just 3 years.

On the fiscal side, the city's contribution to the total of all Federal, State, and local funds spent on the homeless increased by 11 percent between 1984 and 1985. In other words, while the city was adding money, the Feds were taking it away.

But on the bright side, let us look at what Philadelphia has done with a bad situation. Unlike some other places, we did not suddenly discover homelessness during the recent recession. Mandated in part by the 1951 city charter, we have had in place for decades a system of health and social services for which the homeless are the major beneficiaries. Considering total funds spent by the city of Philadelphia for emergency service to individuals, the share directly benefitting the homeless will amount to $14 million in the current fiscal year.

But something very new did begin happening here with regard to homelessness immediately after Mayor W. Wilson Goode took office in May of 1984. To understand it, you should know that religious and voluntary service organizations in Philadelphia have their own long and distinguished history of engagement with the homeless and the transients.

By 1984, many of these organizations were feeling, quite rightly I believe, that city programs were not fully coordinated either among themselves or with parallel programs in the public sector. They felt there was some diffusion of responsibility for the homeless in city government and that consequently their access to services was impaired.

Frankly, there were some near confrontations, but in this community and under this mayor, we have the kind of atmosphere in which a confrontation can swiftly evolve into partnership, and that is the road we have traveled during the past year.

I am astounded at how far we have come. It began last winter with the mayor's appointment of a public-private task force on homelessness with religious, public, volunteer, and corporate representation under the leadership of the cabinet level director of housing.

Initially, there was disagreement about such basics as definition of terms, the composition of the population in need, and the structure of the existing system. All these matters were studied and debated, and a substantial degree of consensus was reached in about 3 months. The task force submitted its report and plan for 1984 to 1985, last summer, including recommendations for $1 million in new programs to fill gaps in the existing service network, and these were approved by the mayor.

An important subcommittee of the task force meets weekly to monitor implementation of the plan and to coordinate efforts of all concerned parties, and the full task force meets quarterly.

Let me outline some of the concrete accomplishments of this process:

First, an assistant managing director reporting directly to me has been appointed to coordinate all involved departments.

Second, a 24-hour intake site for emergency service has been opened, providing assessment, referral and placement.

Third, our winter shelter for 300 men has been opened in a vacant school and is operated under contract by the Red Cross.

Fourth, a 30-bed low demand site for chronically mentally ill will open next month.

Fifth, we have secured a building and some financial support from the Department of Defense for the renovation of a 25-bed shelter for alcoholics.

Sixth, an additional 375 beds have been contracted for the mentally ill, direct single adults and for families.

We have taken from our community block grant funds, $250,000, to fund the development of innovative housing alternatives such as single-room occupancy dwellings in rehabilitated abandoned buildings.

To sum it up, Mr. Chairman, we in Philadelphia know what the problem of homelessness is all about. No data will be uncovered here that will surprise us, we believe. We have a broad-based local coalition spurred by the magnificent example of the volunteer and religious sector and fully supported by the mayor working on this problem.

We have made great progress in the delivery of the emergency services, and it is doubtful that any other city has gone this far. And yet it is not enough. We must acknowledge that our efforts have been largely directed at crisis intervention in the worst case scenarios and have produced benefits and stability for only a fraction of the homeless.

We do not need more emergency shelters, though we ask for help in funding those we have. What we need is permanent housing for those who become semipermanent residents of our emergency shelters. Only the Federal and State governments can provide the startup capital through grants, loans, tax incentives to bring about the emergence of the nontraditional housing options such as single room occupancy, halfway houses, quarterway houses, supportive boarding homes, and the like.

Only the Federal and State governments can provide the income continuance program to the disabled which can make such housing financially feasible to operate.

It has long been agreed that funding for the mentally ill and the addict is primarily a responsibility of Federal and State governments. These are the roots of homelessness, and these are where I urge the committee to seek solutions.

We must agree we share on the city, State, and Federal levels responsibility for the shortcomings in individuals and society that produce homelessness: The lack of jobs, education and opportunity. So we must agree that we share on these same levels responsibility for correcting the effects of our policies.

I have come here today because the city of Philadelphia and the State of Pennsylvania and the cities and States throughout this Nation require the effective and ongoing assistance of the Federal

Government to halt the downward spiral in the lives of thousands of individuals.

Mr. Chairman, I urge you to turn Washington's attention to the real problem. The administration has in the greatest way participated in the creation of this situation. Now we need the Federal Government to pick up the ball that we have been carrying pretty near alone and help us to get this problem solved.

Thank you for this opportunity to speak.

Chairman HEINZ. Mr. Brooks, thank you. I will have some questions for you.

Let me ask Sister Kathleen Schneider to be our final panelist.

Sister Kathleen Schneider, thank you very much for being here. It should be noted that Sister Kathleen Schneider is the administrator of the Mercy Hospice here in Philadelphia.

STATEMENT OF SISTER KATHLEEN SCHNEIDER, ADMINISTRATOR, MERCY HOSPICE, PHILADELPHIA, PA

Sister KATHLEEN. Senator Heinz and all of you who have come to this hearing today, I am a Sister of Mercy and I am the administrator of Mercy Hospice, a Philadelphia center-city shelter for homeless women and children. We can house and provide some social services to 54 women and children. An additional 60 to 80 women come each day for lunch, showers, clean clothing, and a few hours rest and relaxation at the hospice.

We provide outreach services to people one step above homelessness in single room occupancy hotels and to men and women whose only home is the street. We have been working with the homeless for 10 years. We are sponsored by the Archdiocese of Philadelphia and receive no funding from any Government sources whatsoever.

Many of the women we work with at Mercy Hospice are aged and most of them are mentally ill. The numbers grow yearly, for various reasons: Cuts in social services which keep our brothers and sisters victims; unemployment which in time debilitates the most stable of people, and for other reasons that other panelists have given today.

So what can be done about the problem of homelessness among the aged and the chronically mentally ill?

First, we can ask whatever happened to the financial support which was to follow deinstitutionalized people into the communities where they were sent as a result of the enforcement of the Community Mental Health Centers Act.

Second, we can ask whatever happened to the Government's responsibility to see that these people were cared for and helped to wholeness.

Third, we can examine and challenge acts and attitudes on the part of the Federal Government which have helped create and continue to contribute to the systematic worsening of the problem.

Fourth, we can admit that without a constant guaranteed income, people will be homeless. SSI is supposed to be for mentally disabled people, but the process one has to go through to get SSI seems to require a genius level IQ and the skills of a corporate executive.

Social Security offices must be staffed adequately by workers with both the expertise and the heart to understand that mentally ill people cannot always answer questions that seem so simple to mentally well people. Also the SSI determination should not be made by an impersonal panel of judges who never see the applicant. It should be made on the spot by competent people who have dealt personally with the applicant. Social Security workers should be well-schooled in the fact that psychotic people are not the most faithful appointment keepers and that a Social Security worker's job is to help people get the help they need.

Fifth, we can constantly remind the Federal Government of its power to alleviate the housing problems of the poor. Safe and adequate housing for the chronically mentally ill is extremely limited. Chronic means ongoing. Therefore there must be long-term housing for these men and women and creative planning to provide support services, family-type situations, et cetera. We must stop thinking that the poor should be grateful for whatever crumbs fall from the Government's table.

The need for permanent housing solutions is apparent and critical, and has been mentioned over and over again today. Meanwhile, we are in a state of national emergency as far as homelessness is concerned. Of all the years to cut FEMA money by $60 million, this is not the year. Short-term needs must be met, and that will be very difficult this winter. When the cuts are made, it will not be the city projects that will suffer. Rather, the hopes of small groups who waste less money and do things more humanely will go unfulfilled, and the poor are always the ones who lose out in the end.

Sixth, we can make a strong plea for a critical evaluation of the DRG regulations and the involuntary commitment laws which put cutting costs before people. For example, under the DRG's, the length of time a person can be kept in a hospital with an acute psychotic episode is 9 days.

Senator, to get some of our women to swallow a pill takes 9 days. You must realize that these people are victims of the system that discharged them without support from mental hospitals since the sixties, or they are people who have never been able to be hospitalized because their illness developed after the changes in the mental health laws. We are not in any way advocating a return to the warehousing of people in large institutions. Rather, we are saying that since small hospitals have reached the limit of their ability to care for these people, and since larger hospitals continue to reduce the size of their emergency rooms and the number of inpatient beds, resulting in an insufficient number of beds for the mentally ill, and since nursing home redetermination regulations are keeping the aged out, we need help from the Federal Government.

I realize that the recommendations I have made will require that more money be channeled into Health and Human Services than is presently being done. I also realize that this country spends close to $300 billion a year in the name of national security and national defense. It seems to me that a nation that has as many homeless and poor people as we do is not secure, no matter how many cruise missiles, B-1 bombers or Trident submarines we may have. I believe that a society in which life at every stage is valued and in

which the care and feeding of humans is a top priority is its own best defense.

Thank you. [Applause.]

Chairman HEINZ. Sister Kathleen, you have got a very strong following here today, and I include myself as well. Thank you for your excellent testimony.

Let me start, since you have all made a number of very good suggestions, with what I will call the grassroots level question. I am going to ask John Talbott this question.

John, everybody has suggested that there are people who are not identified properly and sometimes even if they are identified, other problems arise. At the most basic level, what we are talking about is outreach and case management.

Who should have the principal responsibility for outreach and where is the accountability for that responsibility now lodged?

Dr. TALBOTT. Let me start with the second part.

It is now not lodged anywhere in most parts of the country because in moving from the single institution of the State hospital to the multiplicity of hospitals, voluntary agencies, SSA, and so forth and so on, one really lost that point of responsibility. It is my own feeling that we are going to have to move toward some reconsolidation of that responsibility. I do not mean necessarily in an institution by any means.

I agree with the Sister totally. That is not what we are talking about.

Chairman HEINZ. Should it be in the private sector or the public sector, and if in the public sector, at the Federal, State, or local level?

Dr. TALBOTT. I think that in terms of service clearly it has to be at the local level.

Chairman HEINZ. The question is divided into two parts, with the first being identification and outreach. Before you can deliver services, you have to know who needs them. It has been true of our system for many, many years that the neediest people are often the last to be served by the system, whatever the system is, because it is easier to find the people who are a little more mobile, a little better educated, still poor, still in need, but more able to get services because they know how to get them. They are able to handle the system better.

As Sister Kathleen said, they have to have an IQ sufficiently above average, frequently, to go down and deal with Social Security and all those fine people down there who, without much training, have to deal with all the people who come to see them.

So, the question is how do we establish accountability for finding these people and then, having found them, what should happen to them after that? Just in general, is this a Federal Government responsibility, a local government and State responsibility? What ought it to be?

Dr. TALBOTT. Again, I happen to think it is a shared responsibility. I think the Federal Government must take some responsibility for the population which is this vulnerable. I think it has to in terms of both housing and in terms of Social Security. It needs to provide those sorts of basic needs.

Chairman HEINZ. You are talking about funding?

Dr. TALBOTT. Funding needs. In terms of the delivery——

Chairman HEINZ. I am not talking about funding. We are going to get to funding. I am trying to analyze the problem.

First, in terms of identifying, let me lay it out for you. Here is the way, unfortunately, my mind works. Before you can solve a problem, you have to know what the problem is. That means you have to identify the people who have needs, and that is called identification and outreach in my vocabulary.

Problem No. 2 is having found them, you want to make sure you do not lose them, and that, in effect, means there is a case management system. Having found the person, having made sure that you have got some form of case management system, the next thing is you want to help solve their problems, at which point money becomes very important because it is one of the components with which you supply services, income and/or housing, which can be provided either directly through public housing authorities, but still requires a rent component as we know, so an income stream such as SSI becomes very relevant. I am not getting to that part of the process. We will get there.

I have got my set of questions for all of you in that regard, but before we can start throwing money at the problem, as they say, we need to make sure that we have a system that really works.

It has been my experience in working with problems of the elderly since 1971 when I became a member of the Government Operations Committee in the House of Representatives that it is critical to first identify and establish contact with the people who need help.

So, I am asking you just your opinion on who should have the primary identification and outreach responsibility. It is not that they cannot be helped by other people, but we have got to establish some accountability. Where should we establish the accountability?

Dr. TALBOTT. That has got to be at the local level.

Chairman HEINZ. It was really a much simpler question than I realized.

Dr. Vieth, do you agree that it should be assessed at the local level, that accountability?

Dr. VIETH. I think it clearly has to be at the local level.

Chairman HEINZ. I am saving Leo Brooks for last.

Sister Kathleen, do you agree it should be established at the local level?

Sister KATHLEEN. Yes.

Chairman HEINZ. Guess who that is. You are the local level, Mr. Brooks, do you agree? Everybody has delegated this to you in their spirit of generosity. Do you agree with them?

Mr. BROOKS. It is, in fact, Mr. Chairman, we who make the contact with the mentally ill homeless, it has certainly got to be at the local level. We do not have any problem with that. In fact, here in the city of Philadelphia, we have established teams that go in the street and they visit the homeless people over and over again, night after night, day after day, to coax them to come into the establishment. Thus far this year, we have talked to some 150 people, and it is very difficult to convince many of them to come in and to stay in shelter.

We have many others who still have not answered the continuous calls, but that has to be done locally.

Chairman HEINZ. To many of the homeless the street is their sanctuary. The street is their place of safety, and it takes a very trusting relationship, involving a lot of time and effort to build up that relationship in order to overcome that predisposition they have. Is that not right?

Mr. BROOKS. Absolutely.

Chairman HEINZ. May I say I had an opportunity to look over a lengthy report of the Philadelphia Task Force on the Homeless that the mayor established about a year or more ago. It is about a 20-page report, and often you hear suggestions that sound very good. Whenever I am involved with social service problems I hear suggestions that what we need are a graduated range of services to help attract people and be responsive to their many needs, and you can categorize their needs in 5 or 10 or 20 different kinds of levels of service. I always scratch my head because that is a monumental job.

In looking through what the city of Philadelphia has done, let me tell you that you have accomplished the monumental.

Mr. BROOKS. Thank you.

Chairman HEINZ. You have a really superb and amazing system. It may not be as much as you want. It may not be as extensive as it needs to be, but you have done a superb job in organizing a variety of levels of care. And I have no doubt in my mind that you are trying to reach all the people, notwithstanding some of the problems that you identified in your statement which I will get to in a minute. But I wanted you to know I am not ignorant of your efforts.

Mr. BROOKS. That is very perceptive of you, Mr. Chairman. It is not just me and not just the Assistant Managing Director. It is several people I see in this audience, and many other people in this city.

Chairman HEINZ. I am well aware of that, and I am sure that the people out there who do all the work deserve that recognition that you have accorded them.

Let me just take the next step which is case management.

Dr. Talbott, you are a psychiatrist. Should psychiatrists be the case managers or should it be someone else?

Dr. TALBOTT. Psychiatrists were the case managers for many, many years before the deinstitutionalization began. More recently, social workers have traditionally fulfilled that role. The family may be indeed the best case management resource if there is no alienation there.

Chairman HEINZ. What about if there is?

Dr. TALBOTT. Then you need a trained case manager in a case management system. That is the starting point. Despite the Mental Health Systems Act attempt to move in that direction nationwide, the services remain very fragmentary around the country. I speak to a great number of community support organizations, and one of the problems case managers have nationwide is they say, fine, I have the cases, but I do not have the resources. And that is a problem that frustrates people who are case managers.

Chairman HEINZ. We are getting there. We are getting there. I just want to establish a few things for the record. I do not have a background as a public prosecutor, but I do like to establish the case record as clearly as possible.

Is there anybody who disagrees with the notion that you do need good case management, that this is principally a local responsibility? Whether or not it is adequate right now, which we will get to in a minute, I see nobody disagreeing with that statement, and I want to compliment Dr. Talbott because he believes apparently that unless you have a very mentally ill person, the best kind of case management is somebody who is fully trained in case management which, I imply, means it may not even be a psychiatrist.

Dr. TALBOTT. Absolutely.

Chairman HEINZ. Absolutely he says it is not a psychiatrist.

Dr. TALBOTT. Sometimes it is and sometimes it is not.

Chairman HEINZ. I thought I had qualified that sufficiently.

We now get to the question that everybody wants to bring up, which is resources. One of the suggestions that we had earlier implied, without necessarily agreeing with the implication, were some suggestions made by Ron Comer that maybe existing resources were not as well targeted as they might be. The reason I say that is that he suggested that States ought to be compelled to come up with the housing plan for the administration of the various housing moneys, and I presume by extension he also had in mind large cities that manage their own housing services, such as the city of Philadelphia and, second, he recommended that there be a task force or commission that sounded somewhat like Dr. Vieth's task force or commission.

Question: Should we be asking the States and the local government to do a better job of targeting their housing programs for the truly neediest people? And there is an implication there which statistically, by the way, is true, that the Federal housing programs just statistically do not reach the poorest of the poor. They tend to reach the slightly better off of the poor. I cannot say whether that is the story here in Philadelphia, but statistically it is a valid point.

I am asking you as to whether you think there can and should be a better mandate for planning and targeting housing for the poor?

Mr. BROOKS. Mr. Chairman, that is an easy notion. That is not an easy accomplishment, and if it had been easy, it would have been done throughout our Nation. The problem is that there are people who have been on lists waiting for public housing and other kinds of housing assistance for as long as 2, 3, 4, and 5 years who, in an economic sense, are broke, but are finding some way to live with somebody or whatnot or live with mothers or their parentage, the grandparents or whatnot.

We are primarily talking about households headed by women. In our public housing in the city of Philadelphia, more than four-fifths of the houses are headed by women who often have no income except for some kind of public assistance. Then it becomes a question of should the person who has been standing in line for 3 years be passed by by someone that we take off the street, should they go in front of them, and that is what the problem is. There are two sides to that issue, whether or not we take one up is the reason that has not been solved.

Chairman HEINZ. I was not being critical. I was asking for your evaluation of Mr. Comer's suggestion.

Mr. BROOKS. I do not think to give a mandate is going to solve that, for somebody to write a bill, because you then have to go in and you still have to deal with individuals at the end of it. I think in the prudence of the Government system that implies that a State legislator or that the Federal Government can distinguish between two people, which one needs the service, and I do not think by some act in Washington you can solve that.

Chairman HEINZ. No, you cannot. That is quite true.

On the other hand, what are the things that my constituents will ask me to say? Senator, you are spending a trillion dollars down there, and even after you get the red out of the budget, you are still spending $700 billion. Why are these people walking around homeless?

Mr. BROOKS. Mr. Chairman, the Federal Government has let down their side of the bargain.

Chairman HEINZ. But, look, you are still spending $700 billion on nondefense programs each year. The money has continued to increase. Mr. Brooks has told you that the city of Philadelphia is not making out and the people there are not making out as well as they used to.

Senator, there has got to be a misallocation of resources. That is what they are telling me. So the purpose of this question is to try and get at the extent to which we are doing a good job and could do a better job of setting priorities.

Let us take a Community Development Block Grant Program which was used in conjunction with some other funds to build a big tunnel in the city. Is that right?

Mr. BROOKS. Yes.

Chairman HEINZ. And that was before either of us, I think, Mr. Brooks, so we can discuss this dispassionately. I mean it was not a good idea. Is it in principle a good idea to use that money which is supposed to be targeted to helping poor people in largest part, a Community Development Block Grant, to build things like tunnels? I mean that is the kind of issue we are trying to get at. [Applause.]

I am not trying to be critical of anybody in saying that, because I think it was a Republican from Philadelphia, Phil Coleman, who signed off on the tunnel. But, on the other hand, we did not have the homeless problem back then that we have now.

Let me ask Dr. Vieth about the notion of the task force that Mr. Comer suggested. Is that not what you are doing?

Dr. VIETH. Yes, it is. Could I mention something in relationship to housing?

Chairman HEINZ. Yes.

Dr. VIETH. As I travel around the country, I try and reflect on what is happening—examining without blaming, but trying to figure out who has responsibility. I think everybody has a role. There is no doubt about it. But one thing comes to mind. Gentrification is going on in cities all over this country—and it is a wonderful thing. But what is being done, as I see it, and it is more and more obvious by the day, is that cities are ripping down housing that homeless people were living in. Maybe that housing is not what we want, but it is better than being in the streets. Developers

are putting up highrises, condominiums, and hotels. That changes tax assessment valuations. It is good for business, but I feel it is at the expense of some of the homeless people. [Applause.]

In Washington, DC, right now we are dealing with a large shelter. Conservatively, the city government would be making $1.5 million every single year, year in and year out, if somebody were to build on that property. The time has come, Mr. Chairman, you said the word is prioritize. There is no doubt that homeless people come under the definition of poverty and need to be considered.

So we have a lot of programs to help the poor, but as far as housing, it has to be addressed by a combination of Federal, State, city, and private sector.

The States do have surpluses; all but two States have surpluses now they have built up because of the economic turnaround. The time has come to prioritize that money to help homeless people. And the important thing is you have a task force for the homeless, you have shelters for the homeless—all levels of government trying to solve the problems. One city had to handle their homeless problem. I think these actions are setting the priorities for use——

Chairman HEINZ. I would like to correct a fanciful notion that a lot of people in Washington, DC, have about the way States keep their books, and I want to correct it for HHS and the President and a number of people.

States have to operate with a balanced budget, unlike some people we know in Washington, DC, and what that really means is that they can never spend more than the revenue they take in and, consequently, since they cannot possibly do that, they always aim to spend no more than or slightly less than is there. So, therefore, a so-called actuarial surplus exists. It is, however, a mistake to think that that surplus represents a bounty to the States. What it means is that they will be able to carry that over and use it just as soon as the new fiscal year starts. That fanciful notion that there is this huge surplus out there, except in a few oil rich States like Alaska and Texas and Oklahoma, is really a bunch of balderdash; and I hope you will so explain to any people who are otherwise minded.

The State of Pennsylvania probably will end the year with a so-called surplus, but the implication of that is we are just swimming in surplus funds, and that is not true.

So, having gotten that off my chest, and I just could not resist——

Sister KATHLEEN. Can I ask you this question about housing, please?

Chairman HEINZ. Yes. I wanted to return to housing.

Sister KATHLEEN. You see, when you run an emergency shelter, one of the dangers—and I think it has been mentioned before—it certainly is not an answer. None of us want to keep in business. We are all hoping you will put us out of business. But one of the things that happens is that we are permanent shelters for people because we cannot find housing.

When you talk about case management, the frustration of case managers is that after they get acquainted with the problem, there is no place to go. There is no place in a mental health system that will take a person chronically mentally ill. If there is not a bed,

there is just no place to put them. So you have this terrible frustration in the health department. You have the frustration of people who are trying to house people. Whereas, you say that more and more money—I do not know where the more and more money comes from. HUD has not given money to the city of Philadelphia. We have units upon units of public housing that are unused. It seems to me it does not take a lot of brains or organization. It takes some money to get somebody in there to clean up the place, get a good manager so somehow or other you can manage those housing units so that poor people walking the streets can be in those houses.

The other thing is that people are put out of houses. We have statistics. A group in the city called the Advocacy Committee for Emergency Services got information to take to Harrisburg about the cuts that you probably know about, but our welfare cuts in Pennsylvania, the people who lost their income and lost their housing and were put in emergency shelters cost the city of Philadelphia thousands and thousands and thousands of dollars; whereas, if someone with some kind of knowhow and money could help the case manager give that person enough money to pay rent for a month, you could have kept them in their own place, they could have been independent human beings. Our system constantly dehumanizes people. [Applause.]

But I believe of every Federal dollar, 1 cent goes to housing for the poor, and that is an absolute outrage. If my statistics are wrong, it might be 3 cents, but I believe it is 1 cent. [Applause.]

Mr. BROOKS. Make that 5 cents and I will support exactly what she has just said.

Chairman HEINZ. I think it is a well-taken point.

Mr. BROOKS. But in 1981 our community development—talking about community development block grants, Philadelphia got $72.4 million. In 1985, it got $61 million. That is just down $9 million. In 1986, we expect it to be $51 million. Down another $10 million. We cannot do what you just described about the increase in permanent structured homes if we are going in the opposite direction in the support money. [Applause.]

Chairman HEINZ. That is not something that I was challenging.

Mr. BROOKS. No.

Chairman HEINZ. What I really wanted to ask about at this point is how we put the pieces of the puzzle together to come up with solutions, because it is clear we cannot rely on the private, nonprivate voluntary sector to provide long-term housing for people who are clearly never going to be able to reenter the work force. They might like to, but it is just not in the cards. We all know what we are talking about without having to single out any of the people who may occasionally use the shelter.

Let me start with a question to Dr. Vieth.

Dr. Vieth, as you look down the road and see what your task force is doing, do you foresee a recommendation as to how we can do a better job of marrying the services that HHS supports or indirectly supports through various kinds of block grants, whether it is title XX or other programs, with the job HUD is supposed to do which is housing and, if so, how are we going to do that?

Dr. VIETH. I think that is already just beginning to crack open. The fact that I chair a task force with all those agency representatives at one table, and the only issue on the agenda is the homeless—what we are doing for them and what impediments they face—shows we are moving in a good direction. As we get more and more understanding, then the task force can look at such issues as the block grant and whether it has enough flexibility. I know with the block grant I manage there is enough flexibility for States and localities to put more and more money into the homeless.

Chairman HEINZ. Do you anticipate you will have concrete recommendations from your task force, and if so, when?

Dr. VIETH. I cannot give you a date on that. We are still developing our relationships with people to get that kind of information, so I would not be able to say.

Chairman HEINZ. Your task force has been in existence over a year?

Dr. VIETH. We have been in existence a year and we have just been funded for the fiscal year beginning October 1. This is the first time we have existed as an organization with designated personnel. Before, I was just reacting with people on detail whom I could utilize.

Chairman HEINZ. Are you going to have some interim reports on what you have accomplished?

Dr. VIETH. We had a hearing with Congressman Weiss, and at that hearing it came up that there was a briefing paper with different options that went to the President. It was a working paper, and right now the White House is looking at those options on how we can improve ties into public-private partnerships to try to address some of the things you are talking about.

As far as HUD, yes, we are looking into ways we can help the homeless more directly. SSA goes into the shelters to identify the people entitled to benefits. There is no way many of the homeless can handle the paperwork. These are things we are working on.

Chairman HEINZ. Mr. Brooks, you have made a number of recommendations in your remarks, and you made a point of singling out the difficulties that have taken place with SSI and Social Security disability with which I think we are both familiar.

If I recollect your statement correctly, you indicated that SSI is much more difficult for the aged, blind, and the disabled, including those mentally ill, to avail themselves of these days.

Are you in a position to tell us why, or maybe Sister Kathleen? It is certainly true that it is difficult for anybody who is not a fairly competent person to navigate any bureaucratic system. But have there been changes on SSI that made it a lot more difficult?

Sister KATHLEEN. Maybe what we are just seeing is that it seems more important now to get SSI because of the welfare cuts, so we are having more and more people go over who up to a point would not identify themselves as being chronically mentally ill because they were getting income and that was all right. It is more difficult and I think the difficulty of having that panel make the decision—I would not want my testimony to sound as if I am criticizing the people, everybody who is working in a Social Security office. I hope you picked that up.

But the fact is sometimes they go over and meet a wonderful person and they are able to make this wonderful statement, yes, I am mentally ill, I need help. And then, somehow or other, that goes on from there to some panel, and they look over some other items and they say, well, she is taken off.

We have a woman who is so chronically mentally ill, everybody who would look at her would know. She went over, she applied. Somewhere or other, there is a house which she has no access to, she cannot fight for, which somebody else is holding onto. That woman has been cut off SSI and is on the street, has no other alternative. The woman who interviewed her had every evidence of it. She went to an impersonal panel and she is off. So that is definitely more difficult. That is definitely a problem for us.

Chairman HEINZ. Let me ask Dr. Vieth. Is your task force going to be addressing the difficulty that Sister Kathleen has just described?

Dr. VIETH. Yes. Anything I bring out of these meetings I take back to HHS. But it is my understanding that there are regulations, new regulations coming out on SSI that could make it easier. I think it is over at OMB for a review right now. I do not have access to that right now, but I will get that to you when they are available.

Chairman HEINZ. You are saying those regulations will facilitate this for these individuals?

Dr. VIETH. Yes.

Dr. TALBOTT. We worked on those regulations and they are better essentially. The principle that you should not be disallowed if you have a previous condition which has not improved has been remedied and there are new specific procedures, so I think that will help.

Chairman HEINZ. I am thoroughly familiar with the new legislation, having worked on it for 3 years. But largely it addresses the review process of the so-called continuing disability investigations which includes about 30 percent mentally disabled people. But in terms of getting back on, if you have not been on, I suspect we had some people on the panel today who have never been on SSI, but who clearly would qualify under any normal interpretation of the rules. But they are not being subject to those reviews because they have never made it in the first place.

Are the new rules going to make it easier to get people who have never been through the system into the system and who clearly need to be in the system?

Dr. TALBOTT. They should. However, just as the law sometimes has not been interpreted the way we intended it to be, maybe the regulations will not be appropriately interpreted either. There is no guarantee.

Chairman HEINZ. Let me ask Mr. Brooks this question.

Mr. Brooks, is there any way we can utilize what remains of the section 8 program to help solve some of these problems? Is there anything we can link it up with, any way we can modify it? This is the assistance housing program I am talking about.

Mr. BROOKS. There may be some technical ways of allowing agencies to go direct. Other than that, I do not know of anything to add at this point. I can go back and study it some more.

Chairman HEINZ. For some years, we have asked HUD to run a Congregate Housing Services Program. It has been a little difficult for HUD to run it because they are not quite used to providing the kinds of integrated services, and this is really for the benefit of senior citizens who in their own way have analogous problems to the mentally ill. That is to say, they need specialized services to help keep them independent, the same as the mentally impaired people, with a different mix of services. It would be useful if we could find a way to work at the local level with HUD to see what we could develop in that area because there is still a considerable amount of resources directed to the section 8 program. Much less than in previous years because we are no longer building under section 8. We are using for the most part existing units and available 20- and 30-year contract authority which caused some problems. You have a point on that, Dr. Vieth.

Dr. VIETH. As members of the task force we go into cities, certainly low-cost housing is the second thing that comes up. The first thing that comes up is how much money we are going to give them. In St. Louis, they are seeking a waiver that would specifically identify a unit for homeless. The city could move people in and out as they become stabilized and were able to manage on their own.

One thing I would like to say before we adjourn is something I have seen in many, many cities with elderly and it is very sad. Elderly have been victimized so much by some of the younger people. In Los Angeles, gangs have come in and taken people's Social Security checks when they come. I am sure you run into this in a lot of other places. The number of homeless elderly could change because they could be frightened and staying away from shelters.

Chairman HEINZ. Sister Kathleen, you wanted to make a point, if I saw you out of the corner of my eye.

Sister KATHLEEN. I was actually going to ask you if you would let Sister Mary answer. She knows a lot about section 8. I could tell you what she tells me, but she could tell you better.

Chairman HEINZ. What I would like to do is maybe have a member of my staff meet with her after the hearing. You all have been very patient witnesses. You have been on the stand, as it were, for an hour.

What I am going to do, with your permission, is to submit to you some additional questions.[1] I have more questions than either you or I have time for, and in addition my staff will be available to talk with you or any other interested people, and I see a few interested, quite a few interested people out there.

Let me therefore simply conclude by thanking you, Dr. Talbott, Dr. Vieth, Leo Brooks, and Sister Kathleen for a very helpful analysis and set of solutions. Let me tell you, just so you do not go away wondering, what I hope that the committee can accomplish with this.

The Aging Committee is not a legislative committee per se, but I sit on the Finance Committee, and we deal with SSI and disability and social services block grants, and a variety of programs in that area.

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[1] See Appendix I on p. 51.

Second, I am the No. 2 person, at least as long as the Republicans control the Senate, on the Banking, Housing, and Urban Affairs Committee. These are my legislative committees and they dovetail rather neatly with this area.

Also, although the mentally ill are not by definition elderly, there are some. They have much in common with the elderly as we discussed in terms of the needs for supportive services, particularly with the trend in our society over the past 20 years of not depending on institutionalization as our response for mental illness.

This is also an area the Health Subcommittee of the Finance Committee, on which I serve, is involved in from time to time and should be actively involved. So it is my hope that the Aging Committee, as we look at both the elderly and other people suffering disabilities, can play a central role, not the only role by any means, in helping to formulate a better national policy. And it is going to take exactly the kind of cooperation that we really have represented here today—the city, the local advocates, the private nonprofit sector, the Federal Government, and the State government. And, of course, although this does not do full justice to Dr. Talbott, from the technical, academic, and professional experts whose advice we also welcome.

So you have not been chosen randomly, and neither is this hearing going to be the end of the matter, but we intend the committee to pursue it and try to work with all of you and others to develop some better solution than what we have now.

We commend all of you for your patience, your time, your attention, your energy, and for also wanting to do something about this problem. Thank you all very much. [Applause.]

[Whereupon, at 11:35 a.m., the committee adjourned.]

APPENDIXES

Appendix 1—Questions and Answers

QUESTIONS FOR LEO BROOKS

QUESTION #1: IT IS CLEAR THAT MANY HOMELESS PEOPLE COULD BECOME ENTITLED TO FEDERAL BENEFITS, SUCH AS FOOD STAMPS, SSI, AND MEDICAID, IF THEY HAD SOME HELP OBTAINING THEM. WHAT IDEAS DO YOU HAVE FOR LINKING HOMELESS PEOPLE TO THOSE BENEFITS? HOW CAN WE PROVIDE REAL CASE MANAGEMENT?

ANSWER: SSI and Medicaid of course may often be the very resources needed to escape from homelessness. I do not think any single entity could undertake case management for the homeless as a group. Case management must be the responsibility of all agencies, public and private, who work with homeless people. Agencies must communicate informally daily, and formally at least weekly, concerning who is managing each case. The federal government can help in two ways:

1) Direct Social Security officials to work closely with local consortia of agencies concerned with the homeless in order to facilitate the filing of applications, case management efforts and follow-up.

2) Promote the formation of local consortia on the homeless through contacts with state and local welfare officials and policy mandates.

Food Stamps pose an additional issue and, if homeless people were eligible, must be dealt with in the same way as cash assistance. Since homeless people have no place to prepare food, purchases of necessity would be limited.

QUESTION #2: WHAT CAN THE FEDERAL GOVERNMENT DO TO HELP PRESERVE, DEVELOP, OR CREATE LOW-INCOME HOUSING FOR THE HOMELESS IN PHILADELPHIA? IS THERE ANY WAY OF TAILORING CURRENT PROGRAMS, SUCH AS SECTION 8, FOR THE HOMELESS MENTALLY ILL? COULD YOU WORK WITH HUD TO ESTABLISH A TRANSITIONAL HOUSING PROJECT SIMILAR TO THE ONE IN MEMPHIS?

ANSWER: One of the most difficult problems confronting the Administration is transforming the housing needs and priorities of the homeless into working programs, while balancing continually shrinking resources. Although providing shelter for the homeless is the City's top priority, funds for support services and operating costs are budgeted primarily from non-Community Development Block Grant (CDBG) resources, in accordance with federal CDBG regulations. However, funds for physical improvements related to sheltering or providing permanent housing for the homeless may be available through existing and future CDBG-funded programs.

The future of CDBG funding becomes more tenuous when one considers the U.S. Department of Housing and Urban Development has informally notified the City to expect yet another reduction of 1 to 2 million dollars for CD Year XI, which begins July 1, 1985. As the amount of federal housing dollars declines, the percentage of the City's population that is homeless, old and/or poor, persons who need assistance the most, increases. This fiscal out-look demands continued attention to leveraging public with private resources to provide the highest possible level of services. In prior CDBG program years, additional resources have been made available for housing and community development activities through Federal, State and private grants. The Federal Government can help Philadelphia preserve low-income housing by replicating past allocations of additional resources, reinstituting Section 8 subsidy programs for existing and moderate rehabilitation, re-allocating HUD re-captured funds from the Philadelphia Housing Authority and adopting an overall policy plan for the up-grading of public housing, similar to the State Neighborhood Assistance Program.

There is a provision in the Section 8 Regulations for Independent Group Residences - A State licensed facility providing a bedroom for each resident and one (1) bedroom for a supervisor of "activities of daily living." Section 8 Certificate holders may be housed in such a residence. However, it should be noted that Independent Group Residences, as described in the Section 8 Regulations, are independently operated and financed.

The Office of Housing would be willing to work with HUD to establish and/or develop any type of transitional housing which would succeed in Philadelphia.

QUESTION #3: HOW MUCH MONEY DOES THE CITY USE FROM THE COMMUNITY SERVICES BLOCK GRANT? HOW IMPORTANT ARE THESE FUNDS TO THE CITY? WOULD THE ELIMINATION OF THE CSBG RESULT IN EVEN GREATER PROBLEMS FOR THE HOMELESS?

ANSWER: The City of Philadelphia annually receives the federal Community Development Block Grant (CDBG). We do not receive a Community Services Grant (CSBG). CDBG regulations to date restricts use of CDBG funds to physical site improvements related to shelter and housing for the homeless. The Philadelphia Housing Authority (PHA), however, receives a $30 million allocation from the CD grant for the rehabilitation of occupied and vacant housing units, which houses many otherwise homeless families. In addition, $250,000 of Year X funds were allocated to develop a Single Room Occupancy (SRO) permanent housing development for the homeless.

We are on the brink of making available long-term permanent housing and transitional housing that would lead to long-term placement. Community Development funds are the only funds currently available to address this need. The preservation of a financially stable CDBG budget and its allocations is crucial to the rehabilitation, acquisition and availability of housing units to homeless families.

QUESTION #4: HAS THE INTERAGENCY TASK FORCE THAT DR. VIETH CHAIRS ACCOMPLISHED ANYTHING THAT HAS DIRECTLY HELPED PHILADELPHIA? HAS THE CITY FOUND FEDERAL AGENCIES SUCH AS THE DEPARTMENT OF DEFENSE, AGRICULTURE, OR HHS COOPERATIVE, OR HELPFUL IN MOBILIZING RESOURCES FOR THE HOMELESS?

ANSWER: Local representatives of the Interagency Task Force and the Department of Defense were very helpful in making a DOD building and associated renovation funds available for a program site. The Social Security Administration has also been very cooperative in the way that I suggested in Question #1 and should become a national model.

QUESTION #5: HOW CAN WE GET THE PRIVATE SECTOR MORE INVOLVED IN ADDRESSING HOMELESSNESS, PARTICULARLY IN THE AREA OF FUNDING PROGRAMS THAT PROVIDE LONG-TERM SUPPORTIVE CARE? IS THERE ANYTHING THE FEDERAL GOVERNMENT CAN DO IN CREATING INCENTIVES FOR PRIVATE SECTOR INVOLVEMENT?

ANSWER: The private sector can become involved either on the basis of charitable contributions or that of business ventures. Charitable involvement is best solicited and promoted at the local level. The federal government, however, is best able to create incentives for business ventures benefitting the homeless, through tax programs or outright grants. Such ventures could include the construction or renovation of single room occupancy dwellings, transitional housing projects, and the like.

The federal government could also help educate the private sector on how to get involved. Too often the only help business knows how to provide is the collection of food, blankets, and other emergency supplies or funds. Often the appropriate incentives are created, the federal government should sponsor conferences and provide consultative services to business showing how to take advantage of them. For example: How can private ventures obtain properties for renovation; obtain zoning approval; put together legal and financial packages; and evaluate the ongoing financial feasibility of operating the projects once constructed?

QUESTIONS, ANSWERS, AND MEMORANDA FROM DR. HARVEY VIETH

Q: In the background paper Secretary Heckler presented to the President early this fall, there is a recommendation that the President issue an Executive Order directing all Federal agencies to give top priority to providing for the homeless, whether through surplus goods, buildings, outreach, etc... Do you know of any plans for such an Executive Order to be issued? Would it help you in getting better cooperation from the various Federal agencies?

A: It is important to note that the background paper did not make recommendations, but rather presented one set of options.

In any consideration of issuing an Executive Order, it is necessary to look at the activities underway. The Task Force on the Homeless has already received excellent cooperation from many Federal agencies in identifying existing resources that can be used to help the homeless. Efforts are well underway to focus these available resources on the problems of the homeless and to identify and target additional resources to this fragile population.

That attached recent memorandum from the Department of Housing and Urban Development and the memorandum and press release from the Department of Defense are examples of the continuing resolution and dedication of the agencies to helping the homeless.

More, of course, can still be done and the Task Force is increasing its efforts. Attached is a memorandum from Secretary Margaret Heckler to all Department of Health and Human Services offices; in this memo, she reemphasizes her commitment to helping the homeless, and makes a statement on the Task Force's mission and agenda for the coming year. These are notable examples of agency efforts which are underway.

THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C. 20410

JAN 8 1985

Honorable Charles Lucas
Mayor of Cincinnati
Cincinnati, OH 45202

Dear Mayor Lucas:

The Department of Housing and Urban Development (HUD) remains committed to continuing its efforts to help provide shelter to the Nation's homeless.

Over the past two years, the Department has taken a number of actions to help shelter the homeless. Single-family acquired homes are available for shelter use and over $53 million of HUD's Community Development Block Grant (CDBG) funds have been used by local governments to acquire and rehabilitate, and operate shelters and facilities. The Department is acting to expand the usefulness of HUD's programs in providing assistance for the homeless as part of the larger Federal effort coordinated by the Department of Health and Human Services' (HHS) Task Force on the Homeless. I want to inform you of the Department's initiatives in this area.

First, as a result of conversations with city government officials and shelter providers, we found that the one-year lease term for single-family HUD-acquired properties was not long enough to justify spending the money to rehabilitate them for shelter use. We have, therefore, amended our policy to permit renewal of the lease for as long as the city wishes to continue to use it for shelter purposes.

Second, we have established a clearinghouse function at our Field Offices to make available to local governments and shelter providers information regarding single-family properties which are available for shelter use. We expect this will help you to be able to use single-family HUD-acquired properties more effectively for emergency shelter.

Third, I want to remind you that CDBG funds may be used to acquire and/or rehabilitate buildings for use as shelters for the homeless. CDBG funds may be used for improvements to a building currently in use as a shelter. Local governments can undertake these activities directly, or the funds can be provided to a non-profit organization to undertake the work. As an example, the city of Birmingham, Alabama used $45,000 of its CDBG funds to renovate an abandoned firehouse, turning it into a shelter which serves 30 to 36 men a night. An inter-denominational church group staffs the shelter.

The costs of operating a shelter are also eligible for CDBG funding as a public service activity. CDBG funds can be used for any of the specific costs of running a shelter: including equipment, such as beds, stoves, and refrigerators; supplies, such as food and blankets; utilities; and staff. However, use of funds for shelter operating costs does fall within the statutory limit (15 percent in most cases) on the use of CDBG funds for providing public services.

Fourth, we have published a proposed regulation to give poor families and elderly individuals who lose their homes through no fault of their own priority for admission to public housing and other assisted housing.

Fifth, to be particularly responsive to the needs of battered spouses, whom we found constituted part of the increase in the homeless population, we intend to include them as among those eligible for priority admission to HUD-assisted housing.

Until the proposed regulation becomes effective, the Public Housing Agency (PHA) which serves your community can admit the homeless under its "emergency" priority admission category. If the PHA does not have this category in its admission policies, but would like to add it in order to house the homeless, the Department will work with the PHA to make this change as quickly as possible. Additionally, if the PHA has some units which it is having difficulty in renting, the Department can authorize it to rent these units to single, non-elderly homeless persons who otherwise would not be eligible to live in public housing.

Sixth, where cities have a need to use single room occupancy (SRO) housing, such as low-cost residential hotels, to provide housing for homeless individuals, we will consider requests for waivers to the regulations for the Section 8 Existing Housing Program to permit assistance to be provided for this type of housing. SRO housing is now eligible for the Section 8 Moderate Rehabilitation program, the new Rental Rehabilitation program, and the new Voucher demonstration.

Serving the homeless is a high Departmental priority. I have directed my Field Office Managers to cooperate with you in any way possible in your efforts to serve the homeless in your community. The Manager of the HUD Field Office which serves your community is:

Mr. Stephen J. Havens
Acting Office Manager - Columbus Office
200 North High Street
Columbus, OH 43215-2499
(614) 469-7345

I am also enclosing a copy of a recent publication of the Department of Health and Human Services (HHS), "Helping the Homeless: A Resource Guide." The guide, which provides "how to" information for both food and shelter operations for the homeless, should prove useful to those in your community who are concerned with addressing the needs of the homeless. The guide also contains an appendix which provides information on how to obtain assistance from the Federal Government, and lists the addresses of the Regional Directors of HHS, who can help you coordinate Federal assistance.

We hope that this information and the changes we have made in our programs will prove useful to you and your efforts to assist the homeless.

Very sincerely yours,

Samuel R. Pierce, Jr.

Enclosure

NEWS RELEASE
OFFICE OF ASSISTANT SECRETARY OF DEFENSE (PUBLIC AFFAIRS)
WASHINGTON, D.C. 20301
PLEASE NOTE DATE

No. 569-84
695-0192 (Info.)
697-3189 (Copies)

IMMEDIATE RELEASE November 1, 1984

DEPARTMENT OF DEFENSE REORGANIZES
SHELTERS FOR THE HOMELESS PROGRAM

Stressing his concern to do more toward aiding the homeless, Secretary of Defense Caspar W. Weinberger has announced new measures to improve the Shelters for the Homeless Program in FY85.

To improve participation, Secretary Weinberger has appointed Assistant Secretary of Defense (Manpower, Installations and Logistics) Lawrence J. Korb responsible for the overall program and has authorized him to send representatives to each city requesting Department of Defense (DoD) assistance. "By managing the progra this way, I hope to expedite agreements between local officials and base commanders," Weinberger said.

Korb will also maintain direct liaison with the Health and Human Services Federal Task Force on the Homeless, and the National Citizens' Committee for Food and Shelter. The Department of Defense will work in partnership with elected officials and religious and charitable organizations. Model leases have also been developed to help organizations enter into agreements with base commanders toward providing shelters for the homeless.

In 1984 the Department of Defense obtained permission from Congress to provide shelters and incidental services for the homeless on its installations. By the end of September 1984, four shelters were operational on DoD bases and two more were being renovated for use by the beginning of November.

"Last year the Department of Defense sought to make a major contribution toward alleviating a great deal of hardship faced by the homeless. I am hopeful that with the changes we have made this year, we can accomplish much more," said Secretary Weinberger.

Religious or charitable organizations desiring more information should contact the Health and Human Services Federal Task Force on the Homeless, (202) 254-6004.

-END-

THE SECRETARY OF DEFENSE

WASHINGTON, THE DISTRICT OF COLUMBIA

29 OCT 1984

MEMORANDUM FOR THE SECRETARIES OF THE MILITARY DEPARTMENTS

SUBJECT: Shelter for the Homeless

Our efforts to help shelter the homeless must continue; the need has not diminished. Our commitment must increase.

The Department has permanent authorization to provide shelter and incidental services (10 USC 2546). We have all the authority we need to be good partners with local elected officials and religious and charitable organizations. There is sufficient money in the Department appropriation for us to absorb the expenses we are allowed to incur even in the absence of a specific appropriation for the purpose of helping provide shelter for the homeless.

By the end of November, six shelters will be operating on our installations. I know we can do more if we try. Because I have determined that our local commanders are not sufficiently familiar with the range of services we can provide and the ways we have accommodated both our normal mission requirements and those imposed by establishing a shelter, I am reorganizing the way in which the program is operated.

I have asked Assistant Secretary Korb to assume responsibility and authority for the implementation of the Department's efforts to help shelter the homeless. Dr. Korb will send a team of people, headed by his personal representative, to each city that requests assistance. I expect each of the Services to provide a senior manager to accompany the OSD representative on site visits in order to ensure that appropriate facilities are identified, agreements are reached quickly, and that no bureaucratic impediments prevent us from offering all the help we can without delay. The task of the team will be to help local officials and installation commanders reach agreement within the framework of the law using the experience gained in the successful negotiations for the existing shelters.

When an installation commander receives a request for help, that request should be transmitted to Dr. Korb immediately. The local group making the request should be referred to the Federal Task Force on the the Homeless and the National Citizens Committee on Food and Shelter. Points-of-contacts are identified in the attached press release.

I know that each of you share my deep commitment to this program. The purpose of the reorganization I have described is to help ensure that our commitment is understood and respected by those in the field who must make our efforts succeed, and provide top-level assistance to our local commanders so we take advantage of every legitimate opportunity to relieve the suffering of the homeless.

Attachment

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 20 1984

Memorandum for: Charles D. Baker, Under Secretary
Dixon Arnett, Deputy Under Secretary for Intergovernmental Affairs
Harvey Vieth, Chairman, Federal Task Force on the Homeless
Assistant Secretaries
StaffDiv, OpDiv

Subject: HHS Actions to Help the Homeless

My commitment to help feed and shelter the homeless remains strong. The need is still there and our efforts must increase.

Several HHS programs can and are being used to help the homeless. By providing them with necessary support services, such as medical care or alcohol and drug abuse assistance, we are attacking the underlying causes of homelessness. I believe we can do even more with our existing resources, and I am asking your help in accomplishing this. Existing resources, adequately targeted towards the needs of the homeless, can help alleviate the problems facing this fragile group.

To better focus our efforts, I am strengthening the Federal Interagency Task Force on Food and Shelter for the Homeless that I established last year. Attached is a paper discussing the problem of homelessness, summarizing the Task Force's accomplishments during the past year, redefining the role of the Task Force, and laying out its agenda for the coming year.

- Under Secretary Charles Baker will oversee the work of the Task Force and the regional offices.

- The Chairman of the Task Force, Dr. Harvey Vieth, is charged with developing general policy on the homeless and identifying useable resources within HHS, as well as maintaining liaison and coordinating with the other federal agencies who are members of the Task Force. He will also coordinate with private sector, national philanthropic organizations, as well as appropriate trade associations, to share information and develop partnerships to aid the homeless.

- Dixon Arnett, Deputy Under Secretary for Intergovernmental Affairs, will work closely with Dr. Vieth to ensure that the Department's policies are implemented by the regional offices. The regional offices will be the day-to-day coordinator of HHS activities on behalf of the homeless and will deal directly with shelter and food bank operators and local government.

I cannot impress upon you enough my commitment to use HHS's resources to help the homeless. Please give the Task Force any help they request. The Task Force telephone number is 254-6004.

Margaret M. Heckler

Margaret M. Heckler
Secretary

December 1984

THE FEDERAL TASK FORCE ON THE HOMELESS

Introduction

In October 1983, Margaret M. Heckler, Secretary of the Department of Health and Human Services (HHS) met with the National Citizens' Committee for Food and Shelter, a private organization which encourages public and private cooperation to obtain housing and food for the homeless. At the meeting, the Secretary offered to take the lead in coordinating a federal effort to work with the Citizens' Committee and on October 31, 1983, she announced the creation of the Federal Task Force on Food and Shelter for the Homeless.

The Task Force, unique as the first interagency unit dealing with the homeless to be established by a departmental initiative rather than by statute, is chaired by HHS and includes representatives from twelve other federal agencies: the Departments of Agriculture, Defense, Interior, Labor, Housing and Urban Development, and Transportation, as well as the General Services Administration, the Federal Emergency Management Agency, ACTION, the Census Bureau, the Veterans Administration and the Postal Service. The Task Force is supported by a small central staff at HHS headquarters and by HHS regional staff assigned by Regional Directors to deal with the problems of the homeless.

The purpose of this paper is to (1) briefly review the activities and accomplishments of the Task Force during the first year of its existence, (2) redefine the role of the Task Force and (3) outline an agenda for the Task Force's support staff at HHS headquarters and in the HHS regional offices. Before doing this, however, it might be useful to describe once more both the problem that gave rise to the Task Force---the problem of homelessness--- and the response to this problem on the part of federal, state and local agencies and the private sector.

What is a Homeless Person?

A homeless person is someone who lacks the financial resources or community ties needed to provide for his or her own adequate shelter. Homeless persons live in public and private emergency shelters, in the streets, under bridges, in subways, bus terminals, airports, railroad stations, parks and abandoned buildings or in temporary voucher hotels, motels or apartments, or in jails or hospitals which they enter with the underlying purpose of seeking shelter.

How Many Homeless Are There?

No one has done a thorough census of the homeless population in the United States. In the absence of one, some advocates for the homeless have claimed that the national total is as high as two million persons and this estimate has achieved fairly wide currency. In May 1984, Secretary Samuel R. Pierce, Jr., of the Department of Housing and Urban Development (HUD), released a systematic national study of those homeless on any one night, which concluded that "as best as can be determined from all available data, the most reliable range is 250,000 to 350,000 homeless persons." According to the report, "this represents the

total number of people, nationally, who were homeless on an average night in December 1983 or January 1984." This number includes both the chronically homeless and those who are temporarily without shelter. Because of the large turnover among the temporarily homeless, the cumulative annual count could well range between two and three times the daily total.

Some commentators have dismissed the argument over numbers as pointless since even the HUD report's lower figure indicates there is a serious problem, given the fact that only one-fourth to one-third of the homeless population can be accommodated in existing shelters. As Philadelphia Mayor William Goode put it: "Let's not waste our time arguing numbers."

Who Are The Homeless?

Studies indicate that around 66% of the homeless are single men, 13% single women and 21% family members. Looked at from another perspective, the homeless generally fall into three categories: people who have suffered recent economic setbacks or eviction, people who have experienced severe, personal crises and people who are chronically disabled by mental illness and/or alcohol and drug abuse (estimated to be from one-half to two-thirds of the homeless population).

In respect to the first group, the so-called "new homeless", the problem is diminishing as a result of the continuing economic recovery which has already created 6.5 million new jobs. The personal crises that are responsible for the second group of homeless---divorce, domestic violence, release from a jail or hospital with no place to go, being stranded while traveling etc. ----are usually temporary in nature, and a large turnover is common among this group.

It is the third group---the chronically mentally ill and the substance abusers---who are not only the most numerous among the homeless, but the most difficult to help. Through the mid-60's, most of the homeless were the so-called skid row alcoholics. After the passage of the 1963 Community Mental Health Centers Act, large numbers of mentally ill persons were released from, or ceased being admitted to, state mental institutions. Nationally, the number in mental hospitals declined from 505,000 in 1963 to 125,000 in 1981 and this resulted in a significant increase in the homeless population. A growing number of States are moving to remedy this situation by providing more money for community-based mental health centers.

Another factor which exacerbated the problems of the homeless was "gentrification" --- the rehabilitation of downtown housing for new affluent purchasers and the demolition of low-cost residential hotels and boarding houses in urban renewal projects. The result was a decline in the supply of single room occupancy (SRO) units lived in by low-income persons.

How Are The Homeless Now Being Helped?

The vast majority of the efforts to assist the homeless are being undertaken by the private sector, including businesses, local non-profit groups, churches and synagogues, and other voluntary organizations. For example, 54 percent of shelters are operated by non-religious private groups, 40 percent by religious groups, and 6 percent by city and county governments. A variety of private sources provided 63 percent (or $138 million) of the 1983 operating expenses for all shelters. In addition, an average of four volunteer staff hours per bed per night was donated to shelters.

In the area of food assistance, in 1983, of the 300-odd food banks in the United States, the 79 which belong to the Second Harvest network distributed to organizations serving the poor some 118 million pounds of food donated by the food industry and other private givers. The dollar value of this food was estimated to be $197 million. Forty percent of this amount (or $78 million worth of food) went to soup kitchens and congregate feeding sites patronized by many homeless persons. In addition under an agreement negotiated by the Task force, some twenty food banks received around 500,000 pounds of surplus food from vendors serving military commissaries.

Local governments also play a major role in the provision of food, shelter and other services for the homeless. According to the HUD report, about 80 percent of local governments (cities and counties) do at least one of the following: operate shelters; give money to private groups to operate shelters or other services; lease or rehabilitate buildings for private shelter providers; and furnish vouchers to homeless persons for use in hotels, motels and apartments.

States have provided services mostly by "passing through" to local governments monies from federal sources such as the Federal Emergency Management Agency, HHS (through the Community Services and Social Services Block Grants), and HUD (through the Community Development Block Grant). Recently, a few States (Maryland, New Jersey, California, Massachusetts and New York) appropriated substantial sums to provide either social services or shelter for the homeless. For example, New York has committed $21 million for construction during FY 1985. In addition, a commission appointed by Governor Cuomo has just recommended allocating $330 million in additional state funds over the next five to eight years for community-based services for the mentally ill. The commission also urged establishment of a system of financing to assure that mental health funds "follow the patient" from the institutions, with each local agency being held accountable for care in its area. Due to the economic upturn, the majority of states are registering a sizeable surplus in state revenues, making it likely that more state funds will be available in the future to help the homeless.

With respect to the Federal Government, there is a mistaken perception on the part of some advocates for the homeless that the Federal Government's

assistance has been limited to the $210 million for emergency food and shelter distributed during the past two years by the Federal Emergency Management Agency. In point of fact, the Federal Government has applied many millions of additional dollars to the problems of the homeless, through such programs as USDA's Emergency Feeding Programs ($1 billion in surplus commodities since 1982, $50 million a year to help pay for the cost of distributing excess foods and $75 million to emergency feeding stations), HUD's Community Development Block Grant ($34 million in FY 1983), HHS's Community Services Block Grant ($62 million in FY 1983 for emergency food and shelter), HHS' Alcohol, Drug Abuse and Mental Health Block Grant ($1.3 million for research grants in FY 1984) and HHS' Program for Runaway and Homeless Youth ($23 million in FY 1984). In the case of the Community Development and Community Services Block Grants, the amounts were not earmarked by Congress but were set by the states administering the block grants. Other block grants which can be utilized by state and local governments for assistance to the homeless include the Preventive Health and Health Services Block Grant, the Social Services Block Grant and the Primary Care Block Grant (also known as Community Health Center Program). It is the prerogative of the states and municipalities to set priorities and determine the percent of these resources that will be directed to the homeless.

In addition, there is a wide range of Federal entitlement programs from which about 20-35% of the homeless are deriving some help. These include Medicaid, Medicare, Food Stamps, Aid to Families with Dependent Children, Social Security Disability Insurance, Supplemental Security Income and Veterans Cash and Medical Benefits (The total dollars received by the homeless under these programs is not known).

Finally, there is the contribution which has been made during the past year by the Federal Task Force on Food and Shelter for the Homeless. The accomplishments of the Task Force to date include ten agreements with federal agencies to support local food and shelter projects. These major sharing agreements consist of the following:

1. An agreement with General Services Administration (GSA) to make vacant Federal facilities, not targeted for other immediate disposition, available for lease to shelter and shelter-related projects. An example of this was the transfer of a vacant federal building at Second and D Streets, NW, to the District of Columbia Government for use as a shelter for 800 homeless people.

2. Another agreement with GSA to donate surplus property to food banks and shelter projects. Food banks and shelter operators can now apply through county or city governments to State Property Offices to requisition surplus property, such as refrigerators, medical equipment, heaters, kitchen supplies, furniture and clothing. To date, approximately 400 community-based providers across the country have requested information from the Task Force on how to gain access to this property.

3. An agreement with the Department of Defense to renovate and lease appropriate facilities to homeless shelter projects at the lowest possible cost. Six such shelters are currently in use, and several others are in the final

stages of negotiation. Secretary Weinberger has just reiterated, in a strongly worded memorandum to all military commanders, his commitment to providing more unused military facilities to organizations serving the homeless.

4. An agreement with the Department of Housing and Urban Development that authorizes HUD Regional Administrators to lease single-family homes in HUD-held inventory to mayors and/or local organizations that support homeless projects. Under this agreement a model project is operating in Memphis, Tennessee, which uses 10 HUD's single-family units to provide interim housing at $1.00 a year to homeless families. The local provider is the Metropolitan Interfaith Association. Several days ago, Secretary Pierce directed his staff to take administrative action to expand the use of single-family acquired properties as emergency family shelters, through intensified publicity and outreach efforts by HUD's regional officials. In the same memorandum, the Secretary ordered the following additional steps to be taken: (1) encourage the preservation of single-room occupancy (SRO) housing through use of several Section 8 programs; (2) provide priority for admission to assisted housing for those who are, or are about to be, homeless, including battered spouses; (3) expand the use of small, vacant Public Housing Authority units by homeless persons and (4) encourage greater use of Community Development Block Grant funds for rehabilitating shelters and providing shelter services.

5. An agreement with the National Guard to make armory facilities or manpower services available to local food bank and shelter operators.

6. An agreement with the Department of Defense under which food banks are linked through HHS with military commissaries and may obtain nonmarketable, surplus foodstuffs through commisary vendors. To date, approximately 120 food banks have been linked with approximately 190 Army, Navy, Air Force and Marine Corps installations. DoD commissaries, like other supermarkets, at times have food that they cannot sell, but that is still edible. This program is designed to get that food to people who will eat it rather than let it go to waste. HHS' ten Regional Directors are responsible for overseeing the day-to-day workings of the agreement.

7. An agreement with the Department of Transportation for Coast Guard commissaries to make nonnmarketable surplus foodstuffs available to food banks.

8. A further agreement with DoD to make warehouse space on military bases available, where appropriate, to food banks for the storage of food.

9. An agreement with the Department of Agriculture that authorizes Farmers Home Administration (FmHA) county supervisors to lease single-family homes to community non-profit organizations for use as shelters. FmHA initially will establish pilot projects in four states.

10. An agreement with the Department of Energy to make shelters for the homeless eligible for DOE grants for weatherization of dwelling units.

In addition, the Task Force conducted a workshop for operators of 30 successful soup kitchens and shelters around the country, and based on this, has just published a "how-to-do-it" guide summarizing various model programs. The guide, the first of its kind to be produced under federal auspices, will be distributed to interested states, localities, institutions and local organizations serving the homeless.

What is the Future Role of the Task Force?

The original charter of the Task Force was based on the following assumptions:

1. Homelessness is essentially a local problem. The problem originates at the community level and the focus of efforts to resolve it must be at this same level. The needs of the homeless are best assessed at the local level and it is only there that the appropriate support and assistance can be pulled together and delivered creatively and with caring. More and more communites are beginning to realize this and are taking the lead by organizing partnerships between businesses, churches, private individuals, care providers and state and local service agencies to establish shelter and rehabilitation facilities for the homeless.

2. New federal programs for the homeless are not the answer. There is a considerable array of existing resources at the federal level which have not yet been fully utilized. These resources include benefit programs for which the homeless are eligible and surplus building space, supplies, equipment and foodstuffs, etc. There are also more resources at the state and local level which can be applied to the problems of the homeless, thanks to budget surpluses generated by the economic upturn.

3. Knowledge of strategies used in many communities to help the homeless needs to be transferred to other communities. The various kinds of things that need to be done to meet the needs of the different categories of homeless persons are all being done now somewhere in the country; what is needed is a systematic effort to document and disseminate what is happening, so that other communites can benefit from this knowledge.

In the light of these assumptions, the role of the Task Force can be summed up as follows:

1. Identifying potential resources controlled by federal agencies.

2. Cutting red tape and helping to remove impediments so that these resources can be more effectively targeted to the homeless.

3. Acting in general as a facilitator or broker between local governments and shelter providers on the one hand and federal agencies on the other, but only when such assistance is requested by a local group and/or local officials.

4. Serving as an information source on homeless issues for the White House, Congress and the provider community.

5. Assisting in identifying examples of successful local approaches to the problem of homelessness and assisting in the dissemination of this information throughout the provider community.

This approach reflects President Reagan's emphasis on community initiative and responsibility, in partnership with federal technical and material assistance.

How will the Task Force Carry out this Role in the Coming Months?

While solid groundwork has been laid and much has been accomplished, a great deal remains to be done to target existing federal resources more directly toward the homeless. The Task Force will be focusing on the following priorities in the coming months:

1. Work with the Social Security Administration (SSA), the states and localities, and shelter operators to identify those shelter residents who qualify under existing law for social security disability or supplemental income benefits. These residents could then provide for their own housing, which could in turn qualify them for other existing programs that require recipients to have a fixed address.

SSA has established, in cooperation with state and local officials, a pilot outreach program in New York city in which claims examiners visit various shelters to counsel residents on their rights, accept benefit applications, and advise residents of the outcome of the application process. Expanding such an outreach program to other areas could signficantly reduce the homeless population through the use of existing resources.

2. Continue to identify existing resources that can be used to help the homeless and produce interagency agreements to make these resources available to organizations serving the homeless. Existing programs for job training, mental health care, alcohol and drug abuse assistance, and other support services could be used to attack the underlying causes of homelessness. The Task Force will also review existing interagency agreements and revise them where necessary.

3. Continue to develop working relationships with national organizations such as The National Citizens Committee for Food and Shelter, the National Mental Health Association, the American Psychiatric Association, the American Institute of Architects, veterans' organizations, etc. These organizations can be of great assistance in mobilizing private sector support throughout the nation.

4. Respond to state and local requests for help by cutting red tape and by furnishing guidance on resources available through HHS' Regional Directors and through other regional and national networks. By acting as a broker between local providers and federal agencies, the Task Force can speed up the application process and, where appropriate, obtain a waiver of restrictive practices.

5. Work with the private sector to ensure that information on resources, methods, and potential problems (and how to deal with them) are available to those who want to set up food banks or shelters. Much of this information is currently available only in a piecemeal fashion from private sector or government computer banks. Access to a central information retrieval system will significantly aid the Federal Government's management of homeless programs and provide a ready source of information for inquiries from Congress, the White House and the press.

6. In concert with other agencies, organize conferences, workshops and regional meetings for shelter operators, service providers and state and local officials, with a view to producing more "how-to-do-it" guides for local use. A case in point is a suggestion that a workshop be held to produce a simplified, easy-to-use reference manual containing brief descriptions of all programs, resources and facilities, both public and private, available to homeless persons and to organizations serving the homeless---a kind of "catalog of domestic assistance" for the homeless.

7. Designate the HHS Regional Directors as the frontline coordinators and implementers of the various interagency agreements negotiated by the Federal Task Force in Washington. The offices of the Regional Directors are the logical places in which to center the efforts of the Task Force. These offices are much closer to the problem than the national office and they are in regular contact with state and local officials who are dealing with the problem. Each Regional Director will be asked to establish and chair a regional task force for the homeless, comprising representatives from GSA, HUD, DOD and other federal agencies where appropriate. The regional task force will go into action only when a local community has determined its need and requests assistance from the task force. Local requests for help reaching the Federal Task Force in Washington directly will be referred to the Regional Directors. The Task Force in Washington will continue to take the lead in establishing general policy and resolving issues affecting more than one region.

Question #2: What role can your Task Force play in getting Social Security to be more aggressive in seeking out potential SSI Recipients in shelters, and in other areas where the mentally ill homeless are found?

Answer

Encouraged by the results of a pilot outreach program in New York, Secretary Heckler directed the Social Security Administration (SSA) to develop a nationwide effort to identify and help serve those many hard-to-reach homeless people who may, on grounds of chronic mental or physical impairment, be entitled to Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) benefits.

Under a plan promulgated in September 1984, SSA regional offices have been asked to designate a field office manager to act as the key contact in large metropolitan centers for community groups which are coordinating services to the homeless. Regional offices also have been requested to compile regional directories of services available to the homeless and distribute these to SSA field offices, SSA teleservice centers, and other agencies involved with assistance to the homeless. Third, each regional office has been asked to name a contact person for homeless initiatives who is to be available to other agencies as a consultant, to share new ideas or approaches for reaching the homeless, and to coordinate SSA field offices activities in this area.

Under the plan, SSA field offices will maintain current information about providers of services to the homeless. They will establish and maintain liaison between the SSA offices and providers of services to ensure that program information is available to providers' staffs, to acquaint providers' staffs with SSA's operational procedures, and to request the providers' assistance in identifying homeless people who may be eligible for benefits. In some cases, especially in areas with large homeless populations, this may involve taking claims at the facilities (such as shelters and soup kitchens) that provide services for the homeless. Field offices are to establish parallel liaison with local mayors' offices or other appropriate levels of local government.

The Task Force is continuing to work with SSA in carrying out this outreach program.

Question #3: If we are ever going to get mentally ill people off the streets and into stable living arrangements, we are going to have to ensure both low income housing and home-based supportive care, which means linking the efforts of HUD and HHS. Do you have any ideas about how we might do this?

Answer

HUD and HHS programs have been linked together to provide for the needs of the chronically-mentally ill (CMI). Between 1978 and 1980, HUD and HHS jointly sponsored a demonstration program for deinstitutionalization of the chronically-mentally ill that was designed to coordinate housing assistance provided by HUD with services funding for the CMI provided by HHS. Under the demonstration, HUD provided funds for housing development through the Section 202 direct loan program and for rental subsidies for the housing units through the Section 8 Program. HHS allowed for certain Medicaid regulations to be waived, at State option, through Section 1115 of the Social Security Act to allow Medicaid funds to pay for the cost of delivery of needed services to the residents. State mental health agencies assisted in the selection of non-profit organizations to develop and operate the housing program, and were expected to play a coordinative and facilitative role with respect to delivery of services to residents.

Participation in the demonstration was competitive, both for States initially, and then for non-profit sponsors of 202 housing within the selected States. In three rounds of applications between 1978 and 1980, 201 sponsors were selected in 38 States, with 1,867 units approved for construction or substantial rehabilitation. A total of $65 million in 202 loan authority and $13 million in Section 8 subsidy funds were reserved for this program.

As a result of the demonstration program, HUD made CMI eligible for the mainstream Section 8 program, beginning in Fiscal Year 1982. Since that time an additional 1,196 units in small group homes and independent living complexes for the CMI have been funded under the Section 202 program. HUD requires that applicants prepare a Service Program Description, describing how their proposed projects will be linked to supportive services needed to maintain chronically mentally ill persons in the community. Since HUD does not provide funding for supportive services, the applicant must provide evidence of funding from other sources. Since HUD does not have expertise in the services need of the CMI, the Department asks State Mental Health Agencies, which receive funds through HHS, to assist in evaluating an applicant's capabilities with regard to the service program description. Participation in the review and evaluation of 202 applications is at the option of the State Agency. State Mental Health Agencies also often assist in providing services funding.

A second mechanism to link HUD and HHS funding to serve the CMI has been used in two states, Colorado and Georgia. These States have used

Question #3 - Page 2

HUD funded Section 8 Existing Housing Certificates to provide housing for the CMI. The CMI are eligible for Section 8 certificates, but have had difficulty in getting housing assistance because of their inability to cope with the necessary procedures and lengthy waiting lists at most housing agencies. State Housing Agencies in Colorado and Georgia got around these problems by establishing set-asides of Section 8 Certificates for use by the State Mental Health Agency in placing the CMI in suitable housing. This arrangement assures both necessary housing assistance and supportive services.

The Veterans Administration (VA) also has programs that help homeless mentally ill veterans. Although the VA does not provide free shelter for indigent veterans, some homeless veterans receiving VA pension or compensation, Social Security, or other funds may qualify to participate in the Residential Care Home Program, the largest of the VA's extended care programs. This program provides residential care, including room, board, personal care and general health care supervision to veterans who do not require hospital or nursing home care, but who, because of health conditions, are not able to resume independent living and have no suitable family resources to provide the needed care. All homes are inspected by a VA multidisciplinary team prior to incorporation into the program and annually thereafter. Care is provided in private homes selected by the VA, at the veteran's own expense. Veterans receive monthly follow-up visits from VA social workers and other health care professionals, and are outpatients of local VA facilities. Currently, over 12,000 veterans are receiving care in over 3,000 homes.

Veterans who have a service-connected mental impairment are eligible for up to 100% disability compensation. In cases where their condition precludes management of their own affairs, the VA will designate a legal guardian to receive and supervise the expenditure of these funds to provide shelter and care for the veteran. In addition, certain veterans are eligible for care in VA domiciliaries and nursing home units, based on medical need and other eligibility criteria.

The Task Force is continuing to work with HHS and HUD as well as other agencies to identify and remove other barriers to a coordinated approach to this problem.

Question #4: We often hear that many homeless, especially the mentally ill homeless, are veterans, and that this population is rapidly expanding. What has the Veteran's Administration been doing to get health and cash benefits to these people? What can be done?

Answer

The VA is required by law to provide benefits and services only to persons who qualify as a result of prior military service under other than dishonorable conditions.

The VA is making a continuous priority effort, through all of its Medical Centers and Regional Offices, to ensure that VA health care and veterans benefits services are readily available to all eligible homeless veterans who file a claim for such services, or seek care at a VA medical facility. In addition, social work staff at each VA medical center facilitate access to VA and community health care services by the homeless through participation in community boards, councils, committees, task forces or advisory groups focused specifically on the needs of the homeless.

Because the VA's computer and records data base for determining or confirming eligibility are based at the VA facilities, it is deemed more efficient to bring the homeless to VA facilities rather than have VA personnel visit the homeless shelters. The shelters should be able to provide transportation to VA facilities for homeless veterans who request it.

The local VA staffs have been given direct responsibilities for meeting the needs of homeless veterans in the surrounding communities, with guidance and necessary backup support provided by the VA Central Office in Washington, D.C.

A recurring problem concerning determination of eligibility lies in the unwillingness or inability of some of the homeless to provide the VA with basic background information, such as name, Social Security number, date of birth and dates of military service.

In an effort to prevent veterans and their families from swelling the ranks of the homeless, the VA regularly counsels veterans who are in danger of default on a VA-guaranteed home loan, making every effort to work with the veteran and the mortgage holder to prevent default and possible eviction.

Question #5: Has your Task Force or anyone at HHS looked into the specific problems of the homeless who are over age 50? Do you have any proposals that would help this group particularly?

Answer

The Task Force is continuing to work with HHS and other agencies to identify and target existing resources to the homeless, including the elderly homeless. Some programs that have been identified so far are discussed below.

HHS's Administration on Aging within the Office of Human Development Services (HDS) will award grants during fiscal year 1985 totalling $404 million for various types of nutrition programs for the elderly and $265 million for other types of services, under Title III of the Older Americans Act. These monies are distributed by formula to the States, which then reallocate it to about 660 Area Agencies on Aging, who are responsible for coordinating and where necessary providing services. While there are some priorities established at the Federal level (in the statute) for the the use of these funds, the decisions on actual expenditures are made by the State and Area Agencies on Aging, including decisions on whether to spend any funds on the homeless.

HDS funded 2 research grants over the last two years specifically focusing on new ways of coordinating and integrating the resources of the public and private sector for the elderly homeless.

As discussed in question #2, the Social Security Administration has an extensive outreach program designed to identify those homeless who qualify for SSA benefit programs.

In addition, HUD provides a substantial amount of housing for the low-income elderly. For purposes of HUD housing assistance, elderly is defined as 62 or older. First, HUD's continued commitment to the Section 8 Certificate Program and the Voucher program benefit elderly families by allowing them to receive housing assistance without having to move. As of December 31, 1983, 40 percent of the approximately 767,000 units made available under the Section 8 Existing certificate program were occupied by the elderly. Second, the Administration recognized that private housing production may not be sufficient to meet the special needs of elderly households. Therefore, it has continued to support Section 8 New Construction subsidies and direct loans for the Section 202 program for the handicapped and the elderly. Since the 202 program was activated in 1974, 130,000 units for the elderly and handicapped bave been built. In FY 1983 14,000 units were funded under this program, and an additional 14,000 in FY 1984. A further 12,000 units are expected to be funded this fiscal year. Third, Public Housing continues to be an important

Question #5 - Page 2

housing resource for the low-income elderly. Almost 600,000 elderly households receive housing assistance through this program. Fourth, Section 8 New Construction and Substantial Rehabilitation programs have provided 425,000 units for the low-income elderly.

The Veterans Administration (VA) also has programs to help elderly veterans who may be homeless. The VA's Community Residential Care Program provides room, board, and supportive care services to 14,000 disabled veterans without homes or families. The beneficiaries can't live alone because of physical or mental illness, but they do not require hospitalization. VA estimates that 85% of them are mentally ill, and that they average 58 years of age. Care is provided mainly in private homes and is paid for by the veterans from VA compensation/pension benefits, SSI, etc., at an average cost of $340 per month. The VA believes this program can serve as a model for local communities and government agencies in addressing the needs of the homeless.

The VA's Domiciliary Care Program serves 8,000 veterans in 16 centers with an average of 400-500 beds. This program provides a group living arrangement for those with minimal medical and rehabilitation needs. The beneficiaries average 62 years of age and must have an income of less than $415 per month.

Many of those in both the Community Residential Care Program and the Domiciliary Care Program would be homeless without these services.

In addition, all non service-connected veterans aged 65 and over are eligible for health care at a VA facility on a space available basis. In general, any veteran qualifying on the basis of medical need, income etc., may be eligible for inpatient care. Outpatient care is generally limited to treatment of service-connected disabilities, but could be provided to prevent hospitalization or as part of pre- or post-hospitalization work-ups.

Question #6: One of the recommendations in the working group paper is the idea of establishing a national clearinghouse on programs, resources, and services for the Homeless to facilitate communication among communities about what is out there to help the homeless. Has the President shown any interest in this idea?

Answer

The Task Force is already working with Partnerships Data Net (a private non-profit computer services firm) and a consortium of non-profit philanthropic agencies to ensure the formation of a central information retrieval system so that information on resources, methods, and potential problems and solutions are available to food and shelter providers. Much of this information is currently available from private sector or government sources, but only in a piecemeal fashion. Access to a central information retrieval system will also significantly aid the Federal Government's management of homeless programs and provide a ready source of information for inquiries from Congress, the press, and the public.

Q: Another recommendation in the background paper is for using both National Health Service Corps Personnel and Public Health Service Commissioned Officers to help provide health care to the homeless. Do you think this is a good idea? Should Congress mandate that this be done?

A: It is important to note that the National Health Service Corps is restricted by law to service in areas which have been designated as underserved. Commissioned Corps officers have permanent, full-time assignments meeting priority national needs, the majority of which are with the Indian Health Service and the National Health Service Corps. The Department is working closely with State and local municipalities to provide an integrated set of primary care services using Federal and other public resources. The best way to meet the needs of the homeless is to bring them into the mainstream of primary care facilities --such as city or county clinics and community health centers --rather than by further fragmenting services.

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January 24, 1985

Honorable John Heinz
Chairman
Senate Special Committee on Aging
SDG-33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the American Psychiatric Association, a medical specialty society representing over 30,000 psychiatrists nationwide, I am grateful for the opportunity to have testified before your Committee at its recent field hearings in Philadelphia on the plight of the homeless mentally ill. Pursuant to your request subsequent to that hearing, I am pleased to provide responses to a number of questions you posed.

QUESTION ONE: You point out that the homeless mentally ill are victims of a disorganized non-system of care, and that we need better accountability and central responsibility for this group. How do we establish this accountability, this goal of having one person responsible for the care of one mentally ill individual? What level of government should be responsible for ensuring that these people do not fall through the cracks?

RESPONSE: As noted in my prepared testimony, Federal, state or local government (depending upon the structure of the program developed to meet the needs of the homeless mentally ill) must designate programs in each region or locale as "core agencies" responsible or accountable for the care of the chronically mentally ill living there. The staff of these agencies must be assigned individual patients for whom they are responsible. In a sense, the system is not dissimilar from that established under the Older Americans Act with the designation of a state agency with statewide responsibility, and Area Agencies on Aging responsible for the coordination of direct service delivery.

The concept as applied to the mentally ill is also not new. The Mental Health Systems Act (repealed in 1981) contained a title which sought to provide many of the outreach, coordination and case management functions required by the chronically mentally ill and other underserved mentally ill in the country. The Older Americans Act (Title IV) in fact, contains the very provision from the Mental Health Systems Act which was developed to meet the needs of the mentally ill elderly.

Certainly, all levels of government should be involved in helping to establish this network of case-managed care for the homeless mentally ill, particularly since all levels of government provide some of the supportive services necessary to provide appropriate

placement, medical treatment, social support and other care required. For example, the National Health Service Corps, which provides health care in medically underserved areas could be utilized to help meet the medical needs of this population. The Federal/State Medicare, Medicaid, SSDI and SSI programs are all involved in providing financial resources to aid these persons. Case management services could be provided by core agencies through local departments of mental and health social welfare. Social service programs cut across all levels of government -- Title XX, state welfare, Food Stamps, etc.

A case could be made, for example, for a "carrot and stick" approach to meeting the needs of this population. Perhaps an incentive under Medicaid (an additional percentage from the Federal government) could be made available to states which establish special case-management programs for the homeless mentally ill. Perhaps housing rehabilitation funds under HUD programs could be similarly utilized. Certainly there would be greater incentive to establish a case-management network of outreach and service provision were some Federal dollars available to help train individuals to perform this function.

These are very much a shorthand series of suggestions, not intended to be complete or inclusive, but intended to stimulate the kind of partnerships which could be forged in this effort.

QUESTION TWO: Why are the mentally ill given short shrift in our health care system? What could we do to Medicaid or Medicare to help the chronically mentally ill, and provide for their longer-term supportive care needs?

RESPONSE: First, I believe it is critical to separate the concept of supportive care needs into two categories: health care needs and social support needs. I believe that each must be addressed, but that we cannot afford to blur the distinction between medical care needs and social support. I believe the question addresses the first of these two categories, and I will therefore restrict my answer to the medical care needs of the mentally ill.

It is unfortunate, but true, that today, mental illness is not a "popular" disease. Fear, stigma and misunderstanding still surround the mentally ill. With 20-30 million Americans now suffering from or likely to be suffering from mental illness, and the availability of substantial treatment for many of those so diagnosed, the illness remains one to be feared, not discussed, not thougth about in the context of purchasing health insurance, and not one routinely reimbursed as other medical illnesses under both Federal and private health insurance plans. The same attitudes which caused the creation of insane asylums in the distant past, have caused the mentally ill to be given short shrift in the health care system.

Even though we know that many of the elderly (perhaps as many as 20 percent) who have been diagnosed as "senile" actually have treatable, reversible mental disorders, public policy has not seen fit to provide health insurance on a level which can allow such individuals to continue as productive, involved citizens. As the Chairman is aware, Medicare itself has

literally institutionalized the discrimination against the mentally ill elederly in its statute -- psychiatric illness is restricted by a lifetime limitation on inpatient care totalling 190 days. Unlike other medical illnesses which are reimbursed on an outpatient basis at 80 percent of the prevailing charge on an unlimited basis, treatment of psychiatric illness under Medicare since enactment has borned a unique 50 percent patient borne copayment and a Federal payment of $250 per year. In today's dollars, that $250 limit translates into about $60, inadequate to cover the cost of treating such illness.

Medicaid, too, is fraught with problems. While physician serivces are madated, states have the capacity to restrict the amount, duration and scope of services to be reimbursed under Medicaid. Not surprisingly, when budget cuts become necessary (as we have learned from the FEHBP program in recent years) the first services to be restricted are those where recipients are not able or willing to advocate for such benefits as treatment of mental illness.

Long-term care is similarly flawed under the Medicare program. No greater than 50 percent of patients in a Medicare funded nursing home may have a primary diagnosis of mental illness for fear of losing certification as a nursing facility. Therefore, patients are (1) turned away if they are suffering from mental illness; (2) not diagnosed as suffering from mental illness as a primary disorder; (3) not treated, even if suffering from a mental disorder because the facility lacks specially trained staff to meet the needs of such patients. Alzheimer's patients are particularly vulnerable since the disease often strikes before the victim is Medicare-eligible; their private insurance will not pay for the kind of psychiatric care and long-term care needed; and Medicaid will not pay unless the patient's family spends down to the poverty level (and then, the above-mentioned restrictions on amount, duration and scope of service exact their tolls.)

What can be done is relatively simple in its construction, and relatively cost effective: Medicare can be "opened" for the mentally ill, as legislation you introduced in the 97th Congress intended, by lifting the existing caps on such care. Medicaid can be amended to ensure that restrictions on amount, duration and scope of service cannot be restricted based on diagnosis or upon physician specialization, and that psychiatric hospitalization is not excluded for those between 21 and 65 as the program is currently codified. Long-term care solutions could be established as part of a far broader policy regarding the long-term care needs of older Americans in general -- an issue with which Congress has yet to grapple successfully in an overall public policy sense. For the mentally ill, however, long-term care would become less expensive if the kind of early intervention financially prohibited under Medicare, Medicaid and many private insurance plans, were not in place.

We also know from recent studies (citation to newest Mumford et. al.) that the cost-benefit of providing psychiatric care in general and to the elderly in particular is a highly positive one. Not only does such care reduce utilization of other health care services, but such reduction more than pays for the cost of the psychiatric intervention, and I have not argued the issues of increased productivity and reduced absenteeism for those employed and receiving psychiatric care for their illness.

In closing, it is critical that the Committee bear in mind that when I

discuss mental illness, I am discussing a medical illness as severe and disabling as many physical ailments. I am discussing a medical condition which, as many other illnesses, can be treated, halted and often reversed. In addition to better insurance coverage of this constellation of illnesses, what is needed is education -- education to the public to debunk myths about the mentally ill; education to help ensure that those suffering from the illness are not afraid to seek the treatment they need; education to the medical appropriateness and value of treatment of the mentally ill.

QUESTION THREE: How do we make deinstitutionalization work, and who is going to take responsibility for ensuring the money follows the patient from the state institution to a community home or facility?

RESPONSE: As noted in my written testimony submitted to the Committee, deinstitutionalization in and of itself is not a bad concept, but absent critically needed psychiatric to the medical as well as a support network available in the community to which an individual is deinstitutionalized -- including the basic life necessities, social services, vocational rehabilitation, etc. -- that person runs the risk of becoming a homeless person. By the same token, community-based care is not the answer for all of those persons whoare now in state or private psychiatric hospitals. There is a small proportion of individuals -- profoundly disturbed, chronic patients, often suffering from a constellation of illnesses -- for whom community-based care is less appropriate than the system of care to be found in a facility. For those individuals, the resources found within the facility should not be curtailed as part of a wider effort to ensure that those who are appropriately deinstitutionalized receive all the medical and other services necessary in the community.

The money which supports the state institution comes from a variety of sources -- SSI, SSDI payments, Medicaid dollars and substantial State financial resources. With those dollars all needs of the patients within that setting are met. If a patient is to be transferred to a community-based setting, the key and critical role of the case-manager (as described in my testimony and in response to earlier questions in this communication) is to set in place the dollars and resources for which the patient is entitled prior to the move from the facility to the community. Coupled with a clear medical plan for treatment in the community setting, the patient may then be discharged. Those dollars and resources include those which have supported the patient in facility (SSDI/SSI,Medicare/Medicaid) as well as other dollars which must precede the patient's discharge (e.g. dollars for housing, for the caseworker him or herself, for clothing and food, for transportation) in the development of a community-based system of care.

A case-manager can help ensure that the deinstitutionalized patient is receiving the entitlements and other fiscal benefits to which he or she is entitled. He or she however cannot be responsible for the Federal/State/Local effort which must be undertaken to ensure that the medical and other systems in the community are there to receive the patient.

QUESTION FOUR: Who should provide crisis services for the homeless mentally ill? Clearly, hospitals don't always want to help, shelters often do

not have the appropriate personnel and community mental health centers are often inadequate.

RESPONSE: It is important to distinguish among several meanings of crisis service before answering this question. A homeless mentally ill person can have a number of critical needs -- immediate shelter, immediate health care, immediate clothing needs, food to prevent starvation. Each of these needs could constitute a crisis, but only one -- health care -- is or should be considered a medical crisis requiring medical intervention. For example, a homeless mentally ill person may require clothing in bitterly cold weather. That critical need does not become a medical need per se until such time as the individual requires medical intervention for instance, for hypothermia.

The APA's Task Force on the Homeless has suggested that the answer that shelters do not have the appropriate personnel to meet the medical needs of a homeless mentally ill person is insufficient. It has suggested that training of shelter personnel is critical in the continuum of community-based care for the homeless and other severely mentally ill. Further, the reason hospitals and CMHCs are not necessarily willing or able to help is inherent in the plight of the homeless -- they lack access to entitlement programs which would allow them to be treated as other than indigent care write-offs by those facilities. (And as noted in a previous response, the entitlement programs are woefully inadequate in meeting the needs of the mentally ill in the best of cases in light of their restrictive coverage.)

One answer to the issue of crisis services lies in the area of commitment and conservatorship. This was spelled out both in our Task Force Report and in my written testimony in which it has been suggested that it must become easier to obtain conservatorship status for outpatients who are so gravely disabled that they cannot care for themselves in the community without legally sanctioned supervision and that involuntary commitment laws must be made more humane to permit prompt return to active inpatient treatment for patients when acute exacerbations of their illnesses make their lives in the community unbearable. At the same time, the concept of outpatient commitment should be explored as a means of ensuring crisis services. We know, for example, that the State of Maryland is looking at developing such a statute at the state level this year.

Until answers such as those I have outlined above are addressed, the most frequent source of crisis intervention has been and will continue to be one of the most inappropriate for the mentally ill -- the criminal justice system.

QUESTION FIVE: Transitional facilities that provide real supportive assistance, psychosocial rehabilitation, and continuous care have proven very successful in many areas, but cost more than shelters. Who will pay for these group homes, halfway houses, and the like? What can we do to stimulate the development of these facilities?

RESPONSE: Just as means have been found to provide the dollars to fund the criminal justice system in this country -- whether Federal, state or local -- so too means must be found to provide the kind of "full service" system for the homeless mentally ill. It has been noted in the Washington Post recently that in the state of Virginia, a person held in prison, convicted of a crime,

can expect to have the State expend upwards of $20,000 per year in his care -- both physical and vocational. This is not inexpensive care.

Certainly the answer is not for the homeless mentally ill to be sent to correctional facilities, since that is among the least appropriate of settings for them, although all too often that is exactly what happens. However, I would suggest that the same constellation of services funded through health care, vocational, housing, food and other Federal, state and local entitlements, could be established in the community for the homeless mentally ill. The cost might or might not be as great, it is difficult to project the effect of economies of scale found in both mental hospitals and correctional facilities upon cost of care, but the dollars which support the economically marginal in general could be turned for use with the homeless as a key subset of that group.

It is important, however, to bear in mind that model facilities will not necessarily work for all people. What works in Philadelphia may not work in Taos, New Mexico. What works for one chronically mentally ill patient may not work for another -- in large measure because one chronically mentally ill patient cannot be seen as identical to another. Nonetheless, such models should be encouraged, just as the Community Support Program should be encouraged, and the model program for meeting the needs of the mentally ill elderly under the Older Americans Act should be encouraged.

QUESTION SIX: What are the implications of the revision of the medical listings for the mentally impaired, required by the 1984 disability amendments, for the mentally ill homeless?

RESPONSE: The work group which developed the revised medical listings for the mentally impaired, required by the 1984 disability amendments provided sound, medical criteria for the establishment of medical disability. Those proposed changes in the listings remain bottled up between DHHS and OMB at this time, in part in a battle over the cost of implementation. The new listings provide a more appropriate, sound basis for DI judgments by state determination services, and we remain hopeful that the continued efforts of the work group to establish better tests for residual functional capacity of the mentally ill will be equally beneficial.

However, for the homeless mentally ill, the SSDI program is often inaccessible. Many will not meet the recency of work test which is required to qualify for SSDI. Those who do qualifty will have to wait an additional two years for the minor benefits for psychiatric treatment available under Medicare. Perhaps most would qualify for SSI based on idigence and mental impairment. However, absent an aggressive effort to locate these individuals, ascertain their status regarding the program, arrange for delivery of the benefit checks, etc., the changes in the SSI/SSDI mental impairment listings will benefit them not at all. Again, the case - management system is important, but equally important is outreach by the DDS in each state. That outreach could form the first link in a chain of activity which will help the homeless, mentally ill receive the benefits to which they are entitled, the care they need, the rehabilitation which may help them escape the streets.

I trust the foregoing provides the further information solicited by your questions.

Sincerely,

John Talbott M.D.

John A. Talbott, M.D.
President

JAT/tf/dt

APPENDIX 2

TENANT ACTION GROUP
MEMBER OF THE NATIONAL TENANTS UNION

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TESTIMONY PREPARED FOR THE SPECIAL COMMITTEE ON AGING

December 12, 1984

The Tenant Action Group (TAG) is a citywide organization of low-income tenants in Philadelphia. Established over ten years ago, TAG's goal is to insure that all Philadelphians have decent and affordable housing.

The vast majority of people who are homeless today were tenants in the not-so-distant past. Much of our work focuses on trying to prevent homelessness by helping tenants to stop illegal or arbitrary evictions, or rent increases which are so high that the tenant is forced to seek new housing.

Since 1978 TAG has assisted over 3,000 tenants each year through its Tenants' Self-Reliance Program. This program provides tenants with information and skills training to enable them to handle immediate housing problems and to prevent the recurrence of such problems.

Almost half of the tenants who contact us for assistance are being threatened with eviction or are undergoing eviction.

Of the people we assisted during the last 15 months, 71% were minority households, 74% were female-headed households, and 84% would be described as "low-income" according to federal guidelines.

Why were these people about to be evicted -- about to become homeless? In almost all cases these tenants had fallen behind in their rent. Yet our investigations reveal that in the vast majority of cases the tenants had used their limited funds to make needed repairs, or to cover high heating bills, or they have withheld their rent because their landlord has refused to make repairs. These actions are rights guaranteed to tenants by Pennsylvania law and court decisions; yet in most cases tenants are unable to take advantage of their rights because of poor documentation, an uncaring judicial system, or landlord harrassment.

In short, adequate and vigorous enforcement of the housing code and tenants rights would halt a large portion of the displacement of the poor, while preserving existing housing stock.

Second, people who depend on public assistance simply receive too little money to guarantee themselves a home. Particularly since the passage of Act 75 (popularly called "Thornfare"), we have noticed a drastic increase in the number of tenants who identify "lack of income" as the sole reason for their failure to pay rent. These tenants are virtually without options to obtain or maintain shelter for themselves and their

families.

In these types of cases we can only attempt to ensure that the proper legal processes take place and make a referral to public and private short-term emergency shelters. As the waiting list for public housing in Philadelphia includes over 11,000 households and entails a five-year wait, public housing is simply not an alternative for such families. Referrals to the publicly funded relocation services merely result in the tenant being offered short-term emergency housing and a list of realtors. But no property owner in the city is going to rent to a person without an identifiable source of income -- and yet this is the quandary facing thousands of Philadelphians at this time.

Thus it is unrealistic -- and cruel -- to separate the existence of homelessness from the cuts in income and entitlement programs and from the desperate shortage of public housing.

Finally, I would like to comment on our experience in distributing federal funds -- provided by the Federal Emergency Management Agency (FEMA) -- to households in need. Our organization has been a primary intake and referral site for tenants in need of cash assistance to meet rental obligations. Last year, working with the People's Emergency Center and the National Temple Non-Profit Corporation, we referred over 150 households for such financial assistance.

It was our experience that the amount of funds made available for such purposes is woefully inadequate; and this year we do not expect to have any funds available until late winter, if at all. What is worse, however, is the fact that those families with the greatest need are not qualified to receive the assistance. The criteria of the various programs always mandate that the household must be able to demonstrate the ability to pay the rent and prevent eviction in the future. Thus, we have only been able to offer this aid to families who do have some hope: those with the promise of a job, or those who are only experiencing a temporary layoff, or those who are short of case because of a medical emergency.

Those households without such hopes are pushed further into the cycle of despair when they learn that they are not eligible for financial assistance because they have no immediate prospect of income. Thus the inadequacy of funding for such rental assistance programs, and restrictions surrounding the use of such funds, contributes to homelessness.

Based on our experience in assisting tenants facing eviction, the Tenant Action Group would like to make the following recommendations to the Senate Special Committee on Aging:

1. That the situation of the aged and mentally ill homeless not be separated from the larger context of the massive and chronic displacement of the poor;

2. That the federal (and state and local) government must

recognize its responsibility to provide levels of funding which can increase the availability of short-term and interim emergency housing for those who have been displaced from their homes;

3. That the federal government must provide funds sufficient to re-hab and thus re-populate the 10% of the existing units of the Philadelphia Housing Authority which are now vacant; and

4. That the federal government must provide funds to create additional subsidized rental housing for very low income persons and households.

Respectfully submitted,

Frank Brodhead for the
Tenant Action Group